Medicaid Industry Jobs Hunter: 11/11/2019

consulting | training | free webinars

clay@mostlymedicaid.com | 919-727-9231

Medicaid Jobs Hunter

In this packet….

1. Health Insurance Specialist (Program Oversight) | Centers for Medicare & Medicaid Services
2. Director Government Affairs - Medicaid LOB | WellCare Health Plans
3. RN - Manager Managed Care Complex Review | Children's Health
4. Director of Medicaid Development &Strategic Growth | Henry Ford Health System and Health Alliance Plan
5. Call Center and Claims Representative Job in Milwaukee, WI - Independent Care Health Plan
6. Budget Analyst | Centers for Medicare & Medicaid Services
7. Senior Solutions Architect job in Houston, TX at Community Health Choice
8. Aetna Life Insurance Company Medicaid Care Management Associate Job in Berkeley Springs, WV
9. Patient Care Coordinator | Healthy Connections
10. Director, Risk Adjustment | EmblemHealth

Health Insurance Specialist (Program Oversight) | Centers for Medicare & Medicaid Services

https://www.linkedin.com/jobs/view/health-insurance-specialist-program-oversight-at-centers-for-medicare-medicaid-services-1608983663/?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 (HHS), Centers for Medicare & Medicaid Services (CMS), Center for Medicare (CM), Medicare Plan Payment Group (MPPG).

As a Health Insurance Specialist (Program Oversight), GS-0107-11/12, you will develop, evaluate, and implement oversight requirements, policies, and operating procedures related to Medicare payment processes and activities.

Responsibilities

- Develop, implement, and maintain a comprehensive program oversight strategy, including standard operating procedures and processes to support Medicare payments.
- Gather and analyze information, conduct various reviews and studies to assess ongoing operations, identify program vulnerabilities, and initiate/recommend improvements or appropriate action.
- Prepare a variety of written products, including position papers, manuals, reports, correspondence, briefing materials, etc. for the assigned program area.
- Establish and maintain relationships with internal and external stakeholders to resolve problems pertaining to program oversight.

- Travel Required
-

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

- Supervisory status
-

- No
-

- Promotion Potential
-

12

- Job family (Series)
  Requirements

  Conditions of Employment
  - You must be a U.S. Citizen or National to apply for this position.
  - You will be subject to a background and suitability investigation.

  Qualifications

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

  In order to qualify for the GS-11, 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-09 grade level in the Federal government, obtained in either the private or public sector), to include: (1) Assisting in the development or revision of processes used for the oversight of a health insurance program; (2) Monitoring entities for compliance with health insurance program regulations and policies; and (3) Preparing briefing materials, manuals, or reports for health insurance program improvements.
  OR -
  Substitution of Education for Experience: You may substitute education for specialized experience at the GS-11 level by possessing 3 full years of progressively higher level graduate education leading to such a degree or Ph.D. or equivalent doctoral degree or LL.M., if related to the position being filled.
- OR -
  Combination of Experience and Education: Only graduate education in excess of the amount required for the GS-09 grade

level may be used to qualify applicants for positions at the grade GS-11. Therefore, only education in excess of a master's or equivalent graduate degree or 2 full years of progressively higher level graduate education leading to such a degree, may be used to combine education and experience.

TRANSCRIPTS are required to verify satisfactory completion of the educational requirement related to substitution of education for experience and combination of experience and education. Please see "Required Documents" section below for what documentation is required at the time of application.

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) Modifying oversight processes of health care or prescription drug service providers; (2) Monitoring entities for compliance with health insurance program regulations and policies; and (3) Conducting reviews to assess for health insurance program operations.

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

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

Experience refers to paid and unpaid experience, including volunteer work done through National Service programs (e.g., Peace Corps, AmeriCorps) and other organizations (e.g., professional; philanthropic; religious; spiritual; community,

student, social). Volunteer work helps build critical competencies, knowledge, and skills and can provide valuable training and experience that translates directly to paid employment. You will receive credit for all qualifying experience, including volunteer experience.

Click The Following Link To View The Occupational Questionnaire

Education

Additional information

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

- **<u>If You Meet The Minimum Qualifications And Education Requirements For This Position, Your Application And Responses To The Online Occupational Questionnaire Will Be Evaluated Under Category Rating And Selection Procedures For Placement In One Of The Following Categories</u>**
  - Best Qualified - for those who are superior in the evaluation criteria
  - Well Qualified - for those who excel in the evaluation criteria
  - Qualified - for those who only meet the minimum qualification requirements

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

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

- Your qualifications will be evaluated on the following competencies (knowledge, skills, abilities and other characteristics):

- Oral Communication
- Oversight
- Policy Analysis
- Written Communication

- This is a competitive vacancy announcement advertised under Delegated Examining Authority. Selections made under this vacancy announcement will be processed as new appointments to the civil service. Current civil service employees would therefore be given new appointments to the civil service; however, benefits, time served and all other Federal entitlements would remain the same.
-

- Background checks and security clearance
-

- Security clearance
-

- Drug test required
-

- No
-

- Position sensitivity and risk
-

Trust determination process
- Required Documents

<u>The Following Documents Are REQUIRED</u>
- **Resumeshowing 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

PLEASE NOTE: A complete application package includes the online application, resume, transcripts (if qualifying through education substitution or a combination of education and experience) and CMS required documents. Please carefully review the full job announcement to include the "Required Documents" and "How to Apply" sections. Failure to submit the online application, resume, transcripts (if applicable) and CMS required documents, will result in you not being considered for employment.

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 11/27/2019 to receive consideration.

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

Please Ensure EACH Work History Includes ALL Of The Following Information

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

- Official Position Title (include series and grade if Federal job)
- Duties (be specific in describing your duties)
- Employer's name and address
- Supervisor name and phone number
- Start and end dates including month, day and year (e.g. June 18, 2007 to April 05, 2008)
- Full-time or part-time status (include hours worked per week)
- Salary

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

application.

- To verify the status of your application, log into your USAJOBS account (
-
- 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 Dana.dessesow@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
-
- Applicants eligible under Schedule A authority who are interested in applying for this position must submit their resume, Schedule A documentation, transcripts (if positive education required or qualifying through education substitution), and cover letter (optional) to Dana.dessesow@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
-
- Agency contact information
-
- Dana Dessesow
-
- Email
-
- Address

-
- Center for Medicare
- 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,11/27/2019, 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.

Director Government Affairs - Medicaid LOB | WellCare Health Plans

LOCATION: Houston, TX

DEPARTMENT: State

REPORTING TO: VP, Government Affairs

Provides policy direction and coordinates efforts of pertinent operating units in matters involving state and federal governments. Ensures the provision of service to the proper administration of Medicare and Medicaid contracts, and maintains effective and cooperative working relationships with federal and state officials. Keeps current on local, regional and national affairs, policies, and legislation affecting health care and specifically, the managed care plan. Advises, develops, coordinates and directs internal policies as they relate to external affairs. Organizes, directs and ensures the compliance of all plan managed care programs with multiple State and Regulatory bodies. Assignments are broad in nature, usually requiring considerable creativity, originality and ingenuity.

Essential Functions

- Oversees and manages policy development.
- Researches, monitors, and analyzes federal and state legislation and planning activities related to government funded initiatives and CMS regulatory changes.
- Reviews and monitors proposed and enacted Federal legislation

impacting the managed care industry and develops business plans accordingly.
- Identifies, analyzes and makes recommendation regarding key legislative issues.
- Manages and directs the activity of federal and state government affairs.
- Works closely with CMS, state legislative leaders and any other government leaders to build coalitions to effect change that will have a positive impact on the managed care market.
- Assists and leads, where appropriate, with issues involving state and federal government relationships, including dealing with regulators to establish and continue effective working relationships.
- Manages and develops direct reports who include other management or supervisory personnel and/or exempt individual contributors.
- Plans, conducts and directs work on complex projects/programs necessitating the origination and application of new and unique approaches.
- Sets operational priorities and manages resources to operational goals and budgets.
- Develops strategies and ensures maximum efficiencies in the utilization of human and financial resources.
- With approval of Senior VP or VP establishes budget and monitors for adherence.
- Ensures corporate initiatives are implemented to achieve optimum results.
- Advises management in long-range planning for areas of specialization.
- Provides technical direction to functional managers, other directors and management.
- Recommends changes in area(s) policy and procedure.
- Performs other duties as assigned.

Candidate Education

- Required A Bachelor's Degree in a related field or Business Administration

- Preferred A Master's Degree in a related field or Public Policy, Public Health, Political Science, Health Administration

Candidate Experience:

- Required 10+ years of experience in planning, development, health policy, legislative affairs, health care consulting or managed health care, and a proven track record of leadership experience in the health care industry.
- Required 5+ years of management experience
- Required Other In-depth knowledge of government programs and the managed care industry and proven experience leading and managing government programs through teamwork, collaboration and open communication.
- Required Other Extensive experience working with key government groups, and the ability to identify and build relationships with key leaders within government health agencies and senior staff on committees that effect healthcare legislation.

Candidate Skills:

- Intermediate Demonstrated leadership skills
- Intermediate Ability to lead/manage others
- Intermediate Demonstrated ability to deal with confidential information
- Intermediate Demonstrated written communication skills
- Intermediate Demonstrated interpersonal/verbal communication skills
- Intermediate Other Provide proactive approach and support to emerging business activities established to remain competitive in the marketplace.

Technical Skills

- Required Intermediate Microsoft Word
- Required Intermediate Microsoft Excel
- Required Intermediate Microsoft Outlook
- Required Intermediate Other Knowledge of and/or ability to utilize COGNOS for budgetary decisions or review.

RN - Manager Managed Care Complex Review | Children's Health

Source URL: https://www.linkedin.com/jobs/view/rn-manager-managed-care-complex-review-at-children-s-health-1566343067/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Job Opportunity **Job ID: 57881**

Title: **Manager Managed Care Complex Review, Dallas, TX**

Position Summary

This position will manage professionals and be responsible for the following areas:

High Cost Drugs

- Build, lead and establish process validation for pediatric high cost drugs and therapies with FDA approval, including early stage projects and post-launch.
- Serve as subject matter expert, and internal/external point of contact related to high cost drugs/therapies.
- Negotiate Single Case Agreements with payers for high cost drugs

and therapies within established parameters. Identifies payor requirements and analyzes payor trends specific to high cost drugs and therapies provided at CHST.
- Educates various departments within CHST and implements action plans to improve efficiencies and reduce denials specific to the payer trends and requirements for high cost drugs and therapies.

Utilization Management- Appeals

- Maintains the denial management process by transitioning inpatient cases to third party vendors for appeals and managing timely filing of appeals throughout the process.
- Monitor concurrent medical necessity denials using appropriate criteria guidelines and consults with Physician Advisor.

Job Profile

ESSENTIAL FUNCTIONS

- Typically manages professional staff and/or team leaders over multiple teams
- Typical span of control: Administrative 8-10, Clinical 10-13, Support Services 11-13; e.g. Admin: Fin, IT, Legal, HR, Public Affairs; Support Services: EVS, Security, Engineering, Food Services.
- Accountable for the performance and results of a team or multiple teams within own discipline
- Adapts unit plans and priorities to address resource and operational challenges
- Provides guidance, coaching, and feedback to team leaders on effective management techniques
- Makes employment decisions for the team, seeking direction from more senior leaders on more complex situations
- Decisions are guided by policies, procedures, and functional priorities; receives guidance from a higher-level manager on high-impact decisions
- Monitors quality metrics and changes in practice that impact clinical, financial, or operational outcomes and develops action plans to address areas for improvement

- Provides guidance to others as needed for non-routine and/or complex problems/situations
- Monitors and manages a budget for defined area of responsibility

Job Specific Responsibilities

- Build, lead and establish process validation and commercialization strategy for high cost drugs and therapies, including early stage projects and post-launch. Responsible for recognizing anticipated new pediatric high cost drugs under clinical trial, and nearing FDA approval, through collaboration with CHST Research and Pharmacy departments.
- Oversight of internal and external relationships (inclusive, but not limited to): serving as liaison between Providers, clinical/non-clinical staff, Specialty clinic/department managers, Managed Care, Finance, HIM, Commercial/ Governmental payers, Hospital Pharmacy, Pharmaceutical company, and Third-Party Vendor for drugs. In collaboration with appropriate parties, identify key stakeholders for introduction of new high cost drug into market; initial/ongoing meetings to recognize Children's Health financial risks; planning/execution of established strategy; assist/serve as expert individual in logistics and developing workflow processes for authorization component; communicate/serve as the point of contact with patient’s family throughout the process.
- Responsible for interaction with medical and support staff to obtain appropriate clinical documentation for accurate indications in patient’s medical record, and completing necessary third party prior authorizations or pre-determinations for high cost drugs/therapies. Corresponds with Managed Care department to receive assistance in resolving payer specific issues. Manages as the content expert for high cost drugs/therapies as drugs/therapies are transitioned to the Specialty clinics.
- Responsible for payor authorization, billing requirements, payor specific medical and pharmacy policies and educate internal departments with requirements. Oversight of negotiating financial and language terms for Single Case Agreements with payers for high cost drugs and therapies within approved parameters.

- Analyze and identity payor trends around high cost drugs/therapies provided at CHST. Manage high dollar accounts to ensure service was authorized and correct payment is received as expected per the terms of the agreement. Lead and collaborate with Case Management, Utilization Management, Admitting, Managed Care, PFS and Payer to resolve any underpaid or denied accounts. Responsible for identifying and trending issues related to high cost drugs processes and payment, developing action plan and ensure resolution.
- Utilization Management: Manages and strategizes for changes in payor or regulatory policies specific to Utilization Management. Read and interprets Medicare, Medicaid, Managed Care contract and clinical policy requirements, monitoring Center for Medicare and Medicaid Services (CMS) guidelines and industry changes. Maintains knowledge of federal, state and other regulatory agency rules and regulations.
- Utilization Management- Appeals: Facilitates the denial management process by transitioning inpatient cases to third party vendors for appeals; including, but not limited to, providing required clinical documentation to support appeal and tracking appeal outcomes. Manages timely filing of appeals as required by payer. Tracks appeals through first, second and subsequent levels. Works collaboratively with Denials Management Specialist to monitor concurrent medical necessity denials using appropriate criteria guidelines and consults with Physician Advisor for unique cases.

Qualifications

Work Experience

- At least 3 years of healthcare experience is required.
- At least 5 years of interaction with patient families is required.
- At least 2 years' experience in leading a team is required.

Education

- Graduate or professional work or advanced degree; or equivalent

experience is required.

Licenses and Certifications

- TX Nursing License

Benefits

Children's Health offers opportunities for learning and career development; competitive pay; and a comprehensive benefits program . We promote a diverse and inclusive workplace. Our team members have a voice in their work through surveys, pulses and town halls. And we honor and celebrate our staff with year-round employee appreciation events.

We invite you to learn more about Children's Health.

Requirements

Job Family Professional & Management

Expertise Accountable Care - Managed Care

Job Type Full Time

Location Dallas, Texas

Director of Medicaid Development &Strategic Growth | Henry Ford Health System and Health Alliance Plan

Source URL: https://www.linkedin.com/jobs/view/dir-medicaid-dev-strat-growth-at-henry-ford-health-system-and-health-alliance-plan-1609291513/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

The Director of Medicaid Development & Strategic Growth provides data-based strategic direction to identify and address opportunities to grow Medicaid membership and continuously improve member, provider, and State experience with HAP. The Director evaluates business drivers including but not limited to capitation rate adequacy, contractual requirements, provider network, community outreach, quality improvement and utilization management activities, and competitive landscape and makes recommendations that best positions the Medicaid product. The Director implements select strategies in collaboration with internal and external colleagues. EDUCATION AND EXPERIENCE: Bachelor¿s Degree required in related field. 10 years¿ experience (5 in leadership), in Managed Care or Medicaid, strong preference for experience in Medicaid Managed Care and Provider Sponsored Health Plans. Experience working in a matrixed organization. Strong financial and analytical skills. Experience contributing to the development of successful Requests for Proposals (RFPs). Strong communication skills. Experience working in deadline driven environments is preferred.

SDL2019-256

Seniority Level

Entry level

Industry

- Insurance
- Health, Wellness & Fitness
- Hospital & Health Care

Employment Type

Full-time

Call Center and Claims Representative Job in Milwaukee, WI - Independent Care Health Plan

Source URL: https://www.careerbuilder.com/job/J3V7TF69RM99RLX3QYP?ipath=CRJR9&utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

$37,742.00 (Careerbuilder est.)

Apply on company site

The position of the Call Center & Claims Representative is intended to meet the needs of iCare members, potential enrollees and providers by providing a resource by phone, to answer member and provider inquiries related to benefits, eligibility and claims, coordinate/assist with member transportation needs, assist in care coordination by working with iCare staff, and perform other duties as assigned.

1. Provides program, benefit, eligibility, claims information and describes iCare services to potential and new members via telephone and in writing.
2. Provide responses to provider inquiries submitted to the dedicated Provider email box on spreadsheets within the designated timeframes based on the volume of claim reviews submitted by the provider.
3. Arranges for translators and translation services, when necessary.
4. Address phone calls from iCare members.
5. Assists with transportation services for members to Medicaid approved locations when necessary.
6. Research issues and uses judgment for obtaining relevant information.
7. Develops and maintains positive customer relations and coordinates with various functions within the company to ensure customer (member or provider) requests and questions are handled appropriately and in a timely manner (24 hours in most cases, longer as needed and customer is provided daily status updates until issue addressed)
8. Documents member information, including demographics and contacts made with customers within the Trizetto Call Tracking system.
9. Meets individual performance and quality goals

Experience and Skills:

1. 2-3 years of demonstrated customer service experience in a health insurance setting with a general understanding of claims processing and benefits.
2. Previous experience in Medicaid and / or Medicare environment.
3. Experience in managed health care systems and customer service

business practices.
4. Strong interpersonal skills and ability to work effectively with persons with disabilities and a wide variety of ethnic, cultural, and socio-economic backgrounds.
5. Ability to develop and maintain effective working relationships with providers, members, other agencies and organizations.
6. Ability to effectively and satisfactorily resolve member and provider issues within specified timelines.
7. Possess knowledge and experience of appropriate telephone skills.

Recommended skills

Medicare

Medicaid

Claims

Health Insurance

Customer Service

Customer Relationship Management

Location

CareerBuilder Estimated Salary What is the Careerbuilder Estimated Salary? Only about 20% of the jobs in our search results contain salary information. When a job posting doesn't include a salary, we estimate it by looking at similar jobs in the same industry in that location. It is not necessarily endorsed by the employer and actual compensation

may vary based on your experience.

This estimation is based on Job title, Industry, Location and Skills

$37,742

Avg. Yearly Salary

Career Path

See the next step in your career

Call Center and Claims Representative

$37,742.00 (Careerbuilder est.)

Sales Representative

Estimated Salary: $70K

Help us improve CareerBuilder by providing feedback about this job:
Report this job

Job ID: 512689-711272

Budget Analyst | Centers for Medicare & Medicaid Services

Source URL: https://www.linkedin.com/jobs/view/budget-analyst-at-centers-for-medicare-medicaid-services-1607995971/?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 (HHS), Centers for Medicare & Medicaid Services (CMS), Office of Financial Management(OFM), Division of Budget Formulation and Presentation .

  As a Budget Analyst, GS-0560-14, you will serve as the technical authority for the planning, development, and presentation of policies and procedures for the formulation of the Federal budget.

  Responsibilities

  - Formulate national health insurance budgets (Medicare/Medicaid/CHIP) based on prior year data.
  - Develop and recommend adjustments and other solutions to ensure compliance with budgets and estimates.
  - Plans, develops, and evaluates policies and procedures relative to the financial and operation of national and state health insurance programs.
  - Prepares and conducts oral presentations and/or briefings for senior OFM, CMS, Departmental, OMB and congressional staffs.

- Travel Required
-

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

position.

- Supervisory status
- No
- Promotion Potential
- 14
- Job family (Series)
- 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) Providing technical oversight on budget formulation actions involving program management and program integrity accounts to budget and accounting staff; 2) Preparing analytical summaries of proposals that would affect expenditures, funding, appropriations, or budget amendments; 3) Analyzing cost data and trends to evaluate the appropriateness, effectiveness, or

other impact resulting from the implementation of law, regulations, policies or operational procedures.

- 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**
- 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:** 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.
-

- **<u>Additional Forms REQUIRED Prior To Appointment</u>**
  - **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, 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):
  - Building Coalitions/Communications
  - Oral Communication
  - Strategic Thinking
  - Technical Competence

- 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>
- **Resumeshowing 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.).** 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.
  <u>PLEASE NOTE:</u> 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.

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 11/18/2019 to receive consideration.

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

Please Ensure EACH Work History Includes ALL Of The Following Information

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

- Official Position Title (include series and grade if Federal job)
- Duties (be specific in describing your duties)
- Employer's name and address
- Supervisor name and phone number
- Start and end dates including month, day and year (e.g. June 18, 2007 to April 05, 2008)
- Full-time or part-time status (include hours worked per week)
- Salary

- **Determining length of general or specialized experience is dependent on the above information and failure to provide**

ALL of this information WILL result in a finding of ineligible.

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

- To verify the status of your application, log into your USAJOBS account (
-

- 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 Valerie.wasserman@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
-

- 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 Valerie.wasserman@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
-

- Agency contact information
-

- Valerie Wasserman
-

- Email
-

- Address
-

- Office of Financial Management
- 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,11/18/2019, 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.
-

Senior Solutions Architect job in Houston, TX at Community Health Choice

Source URL: https://texas.jobing.com/community-health-choice001/senior-solutions-architect?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

	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 Solutions Architect has a major role in providing lead technical services to analyze, design, and deliver clinical/business solutions. Lends expertise to answer technical consulting questions, individually or as part of a project team. Serves as a senior subject matter expert associated with content, processes, and procedures associated with enterprise applications plans. Prepares and

	participates in "deep dive" technical evaluation meetings, investigating processes to understand data and communications flow within Community Health Choice systems applications. Promotes consistency and collaboration with all functional departments with primary focus on optimizing all business processes supported by information technology. Responsible for making recommendations regarding policies associated with the jobs purpose and essential responsibilities. Routine decisions include those regarding systems	

implementation and interaction with systems across Community Health Choice systems / applications.

QUALIFICATIONS:

- Ten years of experience analyzing, designing, and or delivering clinical business solutions (a degree maybe offset experience requirement.
- Five years of relational database management system (RDBMS)

OTHER SKILLS:

- Application and/or Platform Development practices and frameworks
- Solution Architecture and Design
- Project

		Management • Leading /Coaching Others • Working Closely with Business Stakeholders • Problem Solving • Strong Written and Verbal Communication • Technical Competence • Comfort with Ambiguity • Software Testing • Business Process Mapping • Ability to understand business needs and translate those into solution design by leading requirements gathering and ensuring business alignment • Providing leadership to team members on solution design and managing

		technical implementations • Strong experience with full lifecycle software development from design through development, testing, and delivery • Ensuring that uniform enterprise-wide application design standards are utilized and maintained • Collaborating with other business and IT stakeholders to ensure the solution is aligned with business requirements • Strong hands-on platform development and delivery experience • Experience managing projects from

initial requirements through delivery
- Leading and coaching others
- Collaborating with team members to ensure workload aligns with solution design and committed timelines
- Strong written and verbal communication
- Microsoft Office suite, with strengths in Excel, Word, and Visio
- Experience with SCRUM
- Experience running user story workshops
- Experience leading Agile Ceremonies Daily Stand-ups, Sprint Planning, Reviews, and Retrospectives
- Experience with overall Salesforce

		Lightning platform • Experience with Salesforce Administration • Experience with Salesforce administrative functionality such as workflows, processes, user management, etc. • Knowledge of Salesforce API Experience • Experience with Development of custom functionality within Salesforce using Lightning and/or Apex, including API integrations with external systems • experience (with demonstrated knowledge of data types, change control implications, and performance optimization).

	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 IT

Aetna Life Insurance Company Medicaid Care Management Associate Job in Berkeley Springs, WV

Source URL: https://www.glassdoor.com/job-listing/medicaid-care-management-associate-aetna-life-insurance-company-JV_IC1162807_KO0,34_KE35,63.htm?

jl=3414688869&utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Support comprehensive coordination of medical services including Care Team intake, screening and supporting the implementation of care plans to promote effective utilization of healthcare services.
Promotes/supports quality effectiveness of Healthcare Services.
Supports a telephone queue for member welcome calls, as assigned.

- Responsible for initial review and triage of Care Team tasks.
- Identifies principle reason for admission, facility, and member product to correctly apply intervention assessment tools.
- Screens patients using targeted intervention business rules and processes to identify needed medical services, make appropriate referrals to medical services staff and coordinate the required services in accordance with the benefit plan.
- Monitors non-targeted cases for entry of appropriate discharge date and disposition.
- Identifies and refers outlier cases (e.g., Length of Stay) to clinical staff.
- Identifies triggers for referral into Aetna's Case Management, Disease Management, Mixed Services, and other Specialty Programs.
- Utilizes Aetna systems to build, research and enter member information, as needed.
- Support the Development and Implementation of Care Plans.
- Coordinates and arranges for health care service delivery under the direction of nurse or medical director in the most appropriate setting at the most appropriate expense by identifying opportunities for the patient to utilize participating providers and services.
- Promotes communication, both internally and externally to enhance effectiveness of medical management services (e.g. health care providers, and health care team members respectively).
- Performs non-medical research pertinent to the establishment, maintenance and closure of open cases.
- Provides support services to team members by answering telephone calls, taking messages, researching information and assisting in solving problems.
- Adheres to Compliance with Project Management Policies and

Regulatory Standards.
- Maintains accurate and complete documentation of required information that meets risk management, regulatory, and accreditation requirements.
- Protects the confidentiality of member information and adheres to company policies regarding confidentiality.
- May assist in the research and resolution of claims payment issues.
- Supports the administration of the hospital care, case management and quality management processes in compliance with various laws and regulations, URAQ and/or NCQA standards, Case Management Society of America (CMSA) standards where applicable, while adhering to company policy and procedures.
- Supports a telephone queue for member welcome calls, as assigned.
- 2-4 years' experience as a medical assistant, office assistant.
- Familiarity with medical terminology. Managed care experience is preferred.
- Familiarity with Medicaid is desired.
- The highest level of education desired for candidates in this position is a High School diploma, G.E.D. or equivalent experience.

Aetna takes our candidate's data privacy seriously. At no time will any Aetna recruiter or employee request any financial or personal information (Social Security Number, Credit card information for direct deposit, etc.) from you via e-mail. Any requests for information will be discussed prior and will be conducted through a secure website provided by the recruiter. Should you be asked for such information, please notify us immediately.

Aetna is an Equal Opportunity, Affirmative Action Employer

Patient Care Coordinator | Healthy Connections

Job Location

3604 Central Avenue, 71913, Hot Springs, Arkansas

Description

The Patient Care Coordinator works as part of the medical office team performing those clerical duties necessary to prepare patients for a visit, to arrange for payment, and to make reappointments when necessary. Duties include but are not limited to telephone answering, making appointments, preparing electronic charts, sliding fee, and third-party payment information, faxing, scanning, and collecting fees.

Specific Duties and Responsibilities:

Patient Relations:
Primary to check patients in upon arrival for an appointment and initial contact for all walk-in traffic.
Ensures that proper documentation is included for that day's visit as required by HCI's policies.
Copy insurance cards and maintain current insurance documentation in paper and electronic record.
Primary to check-out each patient for which charges have been generated. This includes scheduled patients and walk-in patients that are seeking prescription or other services.
Maintains accurate check-out time and ensure follow-up appointments are scheduled according to the preference indicated by the

patient/provider.
Staff Relations/Team Building:
Participates in meetings and in-services given by the Center.
Helps to implement goals, objectives, policies, procedures, and systems such as Patient-Centered Medical Home (PCMH), Meaningful Use (MU), and other programs or objectives for HCI.
Supports and helps to achieve HCI's clinical and business work plan in accordance with standards required to meet Patient-Centered Medical Home recognition and other programs or objectives for HCI.
Develop collaborative relationships with other departments, services, and community health care agencies to facilitate and support quality care.
Administrative Duties:
Ensure that schedule flow is optimized by checking in patients, and entering demographic patient profiles into the practice management software in a timely manner with an emphasis on keeping the providers on schedule.
Responsible for ensuring that the front desk has adequate assistance during peak appointment times or anytime that the patient load requires a third staff member to effectively handle the volume of patients, with emphasis on keeping the providers on schedule and optimizing patient satisfaction.
Responsible for data entry, money handling, customer/patient relations, and appointment scheduling.
Print chart covers and verify demographic information for each patient.
Verify insurance coverage for medical and dental patients prior to accepting assignment.
Run Medicaid eligibility to ensure coverage for date of service.
Relays "checked-in" status in software so providers will be aware patient is ready to be seen.
Prescription refill assistance, medical records management, and appointment scheduling as necessary to maintain customer satisfaction and/or in the absence of other staff.
Ensure an effective front office operation by coordination of efforts with all staff as necessary to maintain optimum office efficiency.
Responsible for cash handling and daily reconciliation of cash, checks,

charge tickets, and payment arrangements to the daily deposit report.
Maintain inventory of front office supplies and printed documents.
Maintain a clean, clutter-free work environment in the office and reception area.
Demonstrates knowledge of, and supports, HCI's mission, vision, value statements, standards, policies and procedures, operating instructions, confidentiality standards, and the code of ethical behavior.
Maintains confidentiality of all information.
Other duties as assigned.

Director, Risk Adjustment | EmblemHealth

Source URL: https://www.linkedin.com/jobs/view/director-risk-adjustment-at-emblemhealth-1499350217/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Careers at EmblemHealth: For nine decades, EmblemHealth has been making quality health care accessible and affordable for New Yorkers, and helping to make life better in the communities we serve. Our employees are proud of that legacy and want to make health care better for everyone. Here we inspire success while helping employees build meaningful careers. We offer competitive health and welfare benefits,

retirement benefits, and incentive pay plans. Join us for a rewarding experience.

Develop and execute a comprehensive revenue management strategy that improves the quality of care delivered to Emblem members and to ensure the plan reimbursement accurately reflects the clinical diagnosis of our Medicare, Medicaid, and Health Exchange members. Partner with providers to improve the accuracy of their diagnosis coding through education of our risk adjustment programs, incentive models and the ongoing development/ enhancement of support capabilities that complement their clinical practice model. Select and manage best in class vendors to drive continual improvement in the accuracy of diagnosis coding for Medicare, Medicaid, and Health Exchange members. Mange the ongoing performance, compliance and return on investment for each vendor. Create and maintain a capabilities framework that is member and provider centric and is appropriate given for the clinical and demographic dynamics of members in risk adjusted products. Supervise the production of reports and financial analyses required to identify areas of improvement in the data extraction, data submission and data reporting. In charge of the HIP, CCI and GHI risk adjustment data submission process for both the SSP and Medicare products; the revenue for both product lines are 100% contingent on the MEDS and RAPS data submitted to the State and CMS.

Responsibilities:

- Develop, manage and improve all programs to retrospectively identify, retrieve, code and submit diagnostic information from providers on EmblemHealth members for enrolled in Medicare, Medicaid, and Health Exchange products.
- Manage vendor relationships that support these retrospective activities.
- Continually evolve prospective and concurrent revenue management programs that identify members for outreach.
- Work with providers to implement programs through which they 1) identify members based on clinical needs and quality gaps, 2)

outreach to patients to encourage them to make office visits to receive services and 3) completely and accurately document all diagnostic conditions.

- Deliver provider education programs on risk adjustment coding requirements to high volume providers, vendors, global capitation and ACP group leadership to ensure that there is a comprehensive understanding of requirements for documentation, which vary for CMS, SDOH and HHS.
- Manage team completing revenue management opportunities for Medicaid, Medicare and Health Exchange products which includes identification of risk score opportunities, suspects, analysis and tracking of performance and attribution of interventions.
- Create and manage all aspects of revenue management incentive program.
- Direct interaction with the CFO, CEO and other physician leaders of ACP groups and other large, sophisticated medical groups to integrate our programs into the provider's operations.
- Deliver risk management program for simultaneous Federal (CMS) Risk Adjustment processes.
- Manage a project life cycle for the successful development, implementation and maintenance of the Encounter Data Pricing System Submission (EDS) and in addition to EDS, maintain the continued success of the RAPS process.
- Oversee all RAPS extracts and submissions from both internal and external business partners.
- Analyze data to identify submission trends against historic data and membership changes and recommend opportunities to optimize RAPS submissions and CMS revenue. Develop revenue accuracy auditing and monitoring programs for Health Exchange, Medicare and Medicaid products, including prospective, concurrent, and retrospective targeted audits, ongoing risk analysis and identification of systematic interventions to improve accuracy.
- Manage revenue accuracy team which will directly oversee ongoing processes related to risk adjustment data accuracy which will include prospective, concurrent, and retrospective targeted audits focusing on High Volume, at Risk CRG/HCC's, Risk Providers,

random samples, management and oversight of vendor/s that support for internal and external RADV audits Management of risk adjustment audit data repository.
- Collaborate with EmblemHealth medical management, quality, marketing & sales and network departments to identify opportunities to achieve efficiencies and improve effectiveness by integrating both prospective and retrospective programs with care management, CMS Stars, Medicaid and Health Exchange quality programs, sales outreach and provider contracting.

Qualifications:

- Bachelor's Degree in Healthcare, Finance or Business
- Master's Degree, a plus but not required
- Ten plus years of experience, preferably in Healthcare, plan or provider operations and relations; other related experience may also be considered required
- Risk adjustment knowledge and expertise across Medicare, Medicaid, and Commercial exchange required
- Capacity to Multi-task at high detail oriented level required
- Strong working knowledge of MS office applications, specifically Excel, Access knowledge a plus preferred
- Solid analytical and logical skills paired with strong attention to detail required