consulting | training | free webinars

clay@mostlymedicaid.com | 919-727-9231

Medicaid Jobs Hunter

March 4th, 2019

In this packet...

HEDIS Retriever (Seasonal) job at Metroplus Health Plan in New York, NY | StartWire

SourceURL: https://www2.startwire.com/jobs/new-york-ny/hedi-retriever-219225848?source=seo&utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

HEDIS Retriever (Seasonal)

Metroplus Health Plan

New York, NY

Start

Marketing Statement

MetroPlus Health Plan provides the highest quality healthcare services to residents of Bronx, Brooklyn, Manhattan, Queens and Staten Island through a comprehensive list of products, including, but not limited to, New York State Medicaid Managed Care, Medicare, Child Health Plus, Exchange, Partnership in Care, MetroPlus Gold, Essential Plan, etc. As a wholly-owned subsidiary of NYC Health + Hospitals, the largest public health system in the United States, MetroPlus' network includes over 27,000 primary care providers, specialists and participating clinics. For more than 30 years, MetroPlus has been committed to building strong relationships with its members and providers to enable New Yorkers to live their healthiest life.

Position Overview

The primary function of the HEDIS Retriever - Seasonal is to conduct onsite abstraction of services from medical charts in compliance with HEDIS/QARR, Medicare Advantage Star measure specifications. This position will be an integral part of the annual Medical Record Review project required to report HEDIS and QARR measures to the NYS Department of Health and Centers for Medicare & Medicaid Services (CMS). The role is field-based and seasonal (November of the measurement year through May of the reporting year), approximately seven months.

The position requires the ability to travel within the five boroughs daily.

Job Description

- Maintain knowledge of medical record review and EMR systems.
- Maintain up-to-date knowledge of HEDIS, QARR and Star specifications

- Proficiency in MS Office applications, scanning and accurate data entry into MetroPlus systems
- Distribute requests for records and schedules appointments with provider offices to ensure timely completion of duties to meet internal and regulatory standards and requirements.
- Perform abstraction via EMR, in-house paper medical records, on-site provider visits to collect documentation of measure compliance.
- Data enter accurate and timely findings in the appropriate system(s) in accordance with established documentation standards for MetroPlus Health Plan to ensure integrity of member services provided over the continuum of care and over time.

Minimum Qualifications

- High School/GED with a minimum of two years HEDIS review experience. Clinical background preferred (Medical Assistant, Nursing Assistant, Health Educator, LPN, RN, LMSW or LCSW.
- Experience with medical record review working on HEDIS/QARR in a managed care, health plan or provider office setting.
- Proficient in Microsoft Office applications including Word, Excel, PowerPoint and Access.

Professional Competencies

- Integrity and Trust
- Customer Focus
- Functional/Technical Skills
- Written/Oral Communications

How To Apply

If you wish to apply for this position, please apply online by clicking the "Apply Now" button or forward your resume, noting the above Job ID #, to:MetroPlus Health Plan
Human Resources Department
160 Water Street 8th Floor
New York, NY 10038
Attn: Recruitment Unit

CARE MANAGER

SourceURL: https://careers.beaconhealthoptions.com/en-US/job/care-manager/J3P4886KDNKXLTQKNXT?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

CARE MANAGER in Louisville, KY at Beacon Health Options

Date Posted: 3/4/2019

Job Snapshot

Job Description

ABOUT THE POSITION

We are currently seeking a dynamic **Care Manager** to join our team at our office in Louisville, Kentucky. The **Care Manager** will be responsible for The Care Manager (CM) will use clinical and CMSA standards to provide care management to Beacon members on an ongoing basis, within the members benefit package. The CM will initiate and maintain communication with members, Primary Care Physicians, Behavioral Health Providers and other health team members regarding care management plans to collaborate to meet members' needs. The CM is responsible for conducting outreach, assessment, and care coordination/management for identified Medicare Medicaid Alignment. The CM works closely with Health Plan medical care managers, social care managers and others to ensure quality and effective service and support to members, as well as, coordinate amongst all interdisciplinary Care Team (ICT) members to develop the Individualized Care Plan (ICP) and oversee ICP implementation.

Position Responsibilities:

- Complete comprehensive assessment of the medical, behavioral health and psychosocial needs of identified members and their families when delegated by the Health plan.

- Establish and implement culturally competent care management plans to meet the needs of members.
- Create patient centered and culturally competent Individualized Care plan (ICP) to include problem identification, goal-setting, interventions and expected outcomes
- Facilitate and coordinate the appropriate services and supports to meet the needs of enrollees, particularly high-risk populations.
- Provide health coaching and education to members related to health care conditions and treatment plans with a focus on medication and treatment adherence, appropriate use of emergency room, and navigation of the health care system.
- Direct members to self-management tools and resources and support in their use.
- Collaborate with medical and social care managers and Pharmacy to develop a comprehensive and integrated approach to care coordination.
- Participate in rounds forums to promote integrated case discussions and problem-solving
- Make timely referrals for community based services.
- Document care management activities in FlexCare and /or Health Plan Electronic Health Record according to Beacon Standard Operating Procedures.
- Complete care activities in a timely manner and meet compliance requirements for the state Medicaid regulatory HSAG, Medicare NORC, NCQA, and Beacon Clinical Management department standard operating procedures.
- Demonstrate flexibility and creativity in the design of innovative and individualized care plans in order to achieve maximum effectiveness and optimal outcomes for members and their families.
- Participate in member/family meetings to support integrated efforts and collaboration with the health care team
- Provide assistance, advocacy, and empowerment to members in efforts to achieve optimal health
- Supervising a caseload and ensuring all care management activities meet all compliance requirements
- Develop or oversee the ICP for each member in collaboration with all team members, adhering to timelines and including assessment of health needs, individualized care management plans, implementation, monitoring and evaluation of care outcomes.
- When delegated, oversee the clinical process and model of care as delivered by a community based Case Management agency.
- Collaborate with PCP, BHPs, other members of the health care team, Health Plan Complex Care Managers, Social Care Managers, Pharmacy, and others to arrange and coordinate services for the member to help member reach their highest level of functioning and optimize the member's ability to engage in the appropriate plan of care.
- Other duties as assigned

- 35% local travel

Position Requirements:

Education: Master's Degree in a health and/or human service related field

Licenses: Valid Unrestricted license as a LCSW, LCPC, Clinical Psychologist, RN or other master's level behavioral health professional required.

Years and Type of Relevant Work Experience: At least 3 years' experience with SMI population in acute care settings, or case management programs, strong organization skills, ability to multi-task, and proficiency in Word, Excel, and PowerPoint required. Kentuck Medicare and Medicaid, Waiver and Consent decree experience highly preferred. Excellent communication skills (verbal and in writing). Experience working with individuals of different cultural and ethnic backgrounds preferred. Ability to manage multiple priorities and work collaboratively within a team environment required. Managed care experience with familiarity with Medicaid and Medicare populations preferred

TO APPLY

Click below on "Apply for this Position" to create a profile and apply for the position

Beacon Health Strategies, LLC., a Beacon Health Options company, is proud to be an Equal Opportunity Employer as well as a Drug Free Work Environment. EOE/M/F/Veterans/Disabled

$NFD

#CB

PM16

#GD

(4) Senior Director, Medicaid Encounters Operations | Evolent Health | LinkedIn

SourceURL: https://www.linkedin.com/jobs/view/senior-director%2C-medicaid-encounters-operations-at-evolent-health-1148756303/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Senior Director, Medicaid Encounters Operations

Company Name Evolent Health Company Location Chicago, IL, US

Posted Date Posted 2 days ago Number of applicants Be among the first 25 applicants

It's time for a change!

Your Future Evolves Here

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

Are we growing? Absolutely--62% in year-over-year revenue growth through 2015. Are we recognized? Definitely. We're 12th on Forbes' list of America's Most Promising Companies for 2015, one of "Becker's 150 Great Places to Work in Healthcare" in 2016, and our CEO was number one on Glassdoor's 2015 Highest-Rated CEOs for Small and Medium Companies. If you're looking for a place where your work can be personally and professionally rewarding, don't just join a company with a mission. Join a mission with a company behind it.

Director, Medicaid Encounters Operations

Position Description

This position is responsible for the execution of Enterprise Encounter business operations including reconciliation and data management for encounters submissions, encounter rejections and encounter reporting for clients for both EDGE/Marketplace and Medicaid.

Responsibilities

- Lead team responsible for timely, complete, and accurate encounter data submissions that meet or exceed state and/or federal requirements
- Work with HPS business operations and IT Engineering to implement a strategic approach to encounter data management encompassing internal and external data sources, technical infrastructure, process automation, and issue/reject remediation workflow
- Identify, develop and drive initiatives to increase the Encounter Operations function regulatory compliance levels, productivity/efficiency, process consistency, and long-term scalability
- Oversee the on-boarding of new encounter and/or EDGE clients to include requirements gathering/documentation and coordination with HPS Implementation, Business Operations coordination with HPS Engineering teams (as required)
- Develop and execute action plans to respond to new encounter regulatory requirements
- Develop and regularly report on team KPIs and operational and management reports
- Efficiently and effectively manage internal and external escalations
- Develop departmental goals aligned with HPS Business and IT Operations and company strategic objectives
- Identify training needs and initiates development of direct reports

Qualifications

- Bachelor's degree in Healthcare Management, Computer Science or another technology/business field of study
- At least ten years of progressive managerial experience in claims, enrollment, provider and member data management; and enterprise data management (data warehouse, reporting, and health quality measures such as HEDIS)
- Experience in healthcare payer systems required and knowledge of Medicaid products and programs preferred
- Project and/or program management experience
- Process orientation with strong organizational/leadership and analytic skills (troubleshooting, attention to detail)
- Strong verbal and written communication skills for internal and external (clients, state bodies, vendors) from front-line personnel to executive-level staff

Evolent Health is an equal opportunity employer and considers all qualified applicants equally without regard to race, color, religion, sex, sexual orientation, gender identity, or national origin.

(4) Project Manager - Medicaid Services | Wisconsin Department of Health Services | LinkedIn

SourceURL: https://www.linkedin.com/jobs/view/project-manager-medicaid-services-at-wisconsin-department-of-health-services-1151125273/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Project Manager - Medicaid Services

Company Name Wisconsin Department of Health Services Company Location Dane, WI, US

Posted Date Posted 2 days ago Number of applicants Be among the first 25 applicants

- $79,040
- $97,760 a year
- DHS is located at 1 W. Wilson Street in the heart of downtown Madison; near the State Capitol and the Monona Terrace, the Wednesday Farmers'

Market, the Madison Metro route and the Capital City bike path.
State of Wisconsin benefits include nearly 4 weeks of vacation, 9 paid holidays, ample sick time, a top rated health plan, multiple low-cost insurance options, and an exceptional retirement plan. In addition, DHS also offers free on-site yoga classes, indoor walking area and a supportive and collaborative work environment. We offer a team-oriented atmosphere and a focus on work-life balance. Click here to see what working for the State of Wisconsin is all about!
Position Summary:This bureau within DMS is responsible for the maintenance of eligibility determination and enrollments systems for the FoodShare, BadgerCare Plus, Medicaid, Family Planning Services and Caretaker Supplement programs. More than one million citizens throughout the State of Wisconsin are enrolled into these programs. Systems administered by DMS supporting these programs include: Client Assistance for Re-employment and Economic Support (CARES), Access to Eligibility Support Services for Health and Nutrition (ACCESS), Forward Health interChange (iC), and Call Center Anywhere (CCA). These systems are used by Wisconsin citizens, state and county staff (including staff administering the Wisconsin Works and Wisconsin Shares (Child Care) programs at the Department of Children and Families), health care providers, managed care organizations, partners, and vendors to determine eligibility, provide services, and assist Wisconsin citizens with their eligibility-related and enrollment needs. These systems are interconnected to each other as well as other federal, state, and private computer systems through data exchange. The systems are programmed and maintained by vendor staff with State system and policy staff oversight. Coordination within and between programs and systems is complex.
This project manager serves as the CARES Business Manager and is responsible for the general management of the CARES portfolio. This position requires the ability to effectively consult, lead, and coordinate a myriad of activities related to the management of the CARES system. Core functions include governance, strategic planning, portfolio management, project management, and contract management.

- Special Notes:Due to the nature of this position, all applicants will be required to allow DHS to conduct a background check to determine whether the circumstances of any convictions may be related to the job being filled.

Qualifications

Minimum qualifications:

Experience in systems project management. This includes completing tasks such as options analyses, project charters, project plans, defining deliverables and milestones, project schedules, communication plans,

decision logs, risk mitigation plans, project status reports, post project review documentation, etc.
Experience with project portfolio management which includes prioritizing multiple projects, building and managing project dashboards, and reporting and presenting on the status of projects to executive leadership.
Experience leading and coordinating projects that cross business areas or include stakeholders from multiple organizations.
Excellent communication skills.

In Addition, Well-qualified Candidates Will Have

Experience using multiple styles and principles of project management, such as waterfall, agile, lean methodologies, etc.
Experience with vendor management and monitoring vendor deliverables to contractual requirements.
Experience managing projects for highly complex programs (such as involving automation of business or government policy into a major system) with budgets over $500,000.
Experience developing technical solutions to business problems relating to information systems.

- How To Apply:

Click on the link near the top of this announcement to view the qualifications that will be evaluated in the initial part of the selection process.
To apply for this position, click “Log In” to access your existing account or to create a new account if you do not already have an account in the system. After you have logged in, click “Apply Now.” You will be asked to provide your personal information and attach a resume and letter of qualifications in a Word or PDF compatible format. To be considered for this position applicants must complete the online process. Failure to submit all required materials will result in an incomplete application and ineligibility for this position. Application materials will not be accepted if received in an email, as a hard copy or a fax.
Your resume and letter of qualifications are very important parts of your application at DHS and is used during our evaluation process to determine your qualifications as they relate to this job.For suggestions on what to include when developing your resume and letter, please click h

(4) Manager, Health Policy | Fidelis Care | LinkedIn

SourceURL: https://www.linkedin.com/jobs/view/manager-health-policy-at-fidelis-care-1148680156/?trk=guest_job_details_job_title&utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Manager, Health Policy

Company Name Fidelis Care Company Location Clayton, MO, US

Posted Date Posted 2 days ago Number of applicants Be among the first 25 applicants

Position Purpose: Support corporate development and research, evaluate and report on the impacts of regulations, legislation and contractual provisions in new and existing markets.

- Develop and maintain library of state contracts and specific contractual provisions across the corporation in support of contracting
- Review, analyze and prepare state contract negotiation positions in coordination with appropriate corporate, health plan and specialty functional experts
- Compile weekly updates on legislation from each of the corporations states and circulate to government relations, compliance leads and plan presidents
- Develop resources, track progress and monitor efforts to prevent unfavorable policy initiatives
- Collaborate with state and specialty plan leadership to develop policy agendas for the fiscal years
- Manage the organizations policies and objectives involving matters of state and federal health policies
- Provide policy expertise on the healthcare insurance industry, managed care, Medicare, Medicaid program, and Healthcare Reform
- Analyze proposed legislative actions and determine the potential impact on the organization

- Monitor legislative activities, regulatory activities, as well as print and media broadcast and develop the company's position.
  Education/Experience: Bachelor's degree in Health Policy, Public Policy, related field or equivalent experience. Master's degree preferred. 5+ years combined experience of health policy, public policy, contract negotiation or related experience. Previous experience as a lead in a functional area, managing cross functional teams on large scale projects or supervisory experience including hiring, training, assigning work and managing the performance of staff.

  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.

  Job

  Health Insurance Operations

  Primary Location

  USA-Missouri-Clayton

  Organization

  Corporate

  Schedule

  Full-time

(4) Nurse Case Manager Case Management | PacificSource Health Plans | LinkedIn

SourceURL: https://www.linkedin.com/jobs/view/nurse-case-manager-case-management-at-pacificsource-health-plans-1151653140/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

(4) Nurse Case Manager Case Management

Overview

Provide utilization management services which promote quality, cost-effective outcomes by helping the Medicaid/Medicare member populations achieve effective utilization of healthcare services. Incorporate the essential functions of professional case management concepts to enhance patients' quality of life and maximize health plan benefits. These functions include, but are not limited to:

- Coordination and delivery of healthcare services
- Consideration of physical, psychological, and cultural factors
- Assessment of the patient's specific health plan benefits and additional medical, community, or financial resources available

Responsibilities

- Collect and assess patient information pertinent to patient's history, condition, and functional abilities in order to develop a comprehensive, individualized care plan that promotes appropriate utilization, and cost-effective care and services.
- Perform concurrent review of patients admitted to hospitals. Maintain telephone contact with the hospital utilization review personnel to assure appropriateness of continued stay and level of care. Identify cases that require discharge planning, including transfer to skilled nursing facilities, rehabilitation centers, home health or hospice services.
- Review referral and preauthorization requests for appropriateness of care within clinical guidelines. Incorporate knowledge of mortality, morbidity, and established standards of practice associated with surgical procedures, pharmaceuticals, medical and behavioral health diagnoses.
- Identify catastrophic and/or high exposure cases, case management, behavioral health or utilization review issues, pertinent inquiries, problems, and decisions that may require review. Work with direct supervisor for reporting these cases.
- Interact with other PacificSource personnel to assure quality customer service is provided. Act as an internal resource by answering questions requiring medical or contract interpretation that are referred from other departments, as well as physicians and providers of medical services and supplies. Assist

employers and agents with questions regarding healthcare resources and procedures for their employees and clients.

Supporting Responsibilities

- Meet department and company performance and attendance expectations.
- Follow the PacificSource privacy policy and HIPAA laws and regulations concerning confidentiality and security of protected health information.
- Perform other duties as assigned.

Qualifications

Work Experience: Five years nursing experience with varied medical exposure and experience required. Experience in case management, including cases that require rehabilitation, home health, and hospice treatment. Insurance industry experience preferred.

Education, Certificates, Licenses: Registered nurse with current unrestricted state License.

Knowledge: Thorough knowledge and understanding of medical procedures, diagnoses, care modalities, procedures codes including ICD-10, DSM-IV, and CPT Codes, health insurance and State-mandated benefits. Thorough knowledge and understanding of contractual benefits and options available outside contractual benefits. Thorough knowledge of community services, providers, vendors and facilities available to assist members. Thorough knowledge of creating appropriate case management plans. Ability to use computerized systems for data recording and retrieval. Assures patient confidentiality, privacy, and health records security. Establishes and maintains relationships with community services and providers. Maintains current clinical knowledge base and certification. Ability to work independently with minimal supervision.

Competencies

Our Values

- Building Customer Loyalty
- Building Strategic Work Relationships
- Continuous Improvement
- Adaptability
- Building Trust
- Work Standards
- Contributing to Team Success
- Planning and Organizing
- We are committed to doing the right thing.
- We are one team working toward a common goal.
- We are each responsible for our customers' experience.

- We practice open communication at all levels of the company to foster individual, team and company growth.
- We actively participate in efforts to improve our many communities-internal and external.
- We encourage creativity, innovation, continuous improvement and the pursuit of excellence.

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

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

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

(4) Senior Analyst, Medicaid ACO | Steward Health | LinkedIn

SourceURL: https://www.linkedin.com/jobs/view/senior-analyst%2C-medicaid-aco-at-steward-health-1152337961/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Senior Analyst, Medicaid ACO

Company Name Steward Health Company Location Dedham, MA, US

New Posted Date Posted 8 hours ago Number of applicants Be among the first 25 applicants

Senior Analyst, Medicaid ACO
Category: Management/ Professional Schedule:
Facility: Steward Health Care Network Shift:
Department: Steward Health Care Network Hours:
Req Number: 53384 Union: No

Job Details

POSITION SUMMARY:

Reporting to the Analytics Manager, the Senior Analyst serves as the key analytic resource to meet the information, reporting, and analytic needs of Steward Health Care Network (SHCN)''''s Medicaid Accountable Care Organization.

Key Responsibilities

As a critical member of the SHCN Analytics Team, the Senior Analyst performs the following functions:

- Conducts sophisticated business analyses to support Medicaid ACO program development and ongoing operations, grounded in deep expertise and functionality with both internal and publicly available Medicaid-related health care data sources
- Develop comprehensive, timely and accurate analyses, reports and presentations on utilization, leakage, risk performance, care management, and quality metrics on Medicaid ACO care risk contracts for SHCN''''s Medicaid ACO
- Deliver accurate and on-time deliverables, including dashboard reports, cost estimates, models and ad-hoc analyses
- Track and evaluate key performance metrics
- Work with business and operational leaders to identify TME opportunities and quantify ROI for related programs
- Coordinate with Steward''''s internal data, analytics, and information technology teams to manage data and reporting related to Medicaid programs
- Identify opportunities to improve and enhance the analysis and information provided to SHCN leadership, participating network providers, and community partner organizations

- Work with analysts and analytic tool vendors to improve standard report design
- Support ad hoc analytic requests, providing accurate and timely data, analysis and insightful interpretations

Required Knowledge & Skills

- Possess strong analytic and technical skills plus an ability to translate complicated data into useable information;
- Ability to work on multiple projects simultaneously, deliver work products on deadline, and respond to new requests with fast turn-around, as needed
- Strong skills in SQL, Excel, PowerPoint; one or more years of BI tool experience preferred (Qlik, Tableau)
- Ability to be thorough and be careful about details
- Excellent working knowledge of statistics
- Organizational and project management skills to manage projects effectively;
- Demonstrated knowledge of relationships between health plans and providers, including detailed understanding of health plan data and familiarity with Medicaid and other public programs;
- Possess an in-depth understanding of claims data, including ICD-9 & CPT codes, DRGs, health status and risk adjusters;
- Excellent verbal and written communication skills, including the ability to graphically present complex data; outstanding interpersonal skills; and ability to relate positively with individuals at all levels of the organization
- Creative, flexible, and self-motivated with sound judgment; ability to plan and implement;
- Commitment to service excellence

Education/Experience/Licensure/Technical/Other

Education: BA/BS required; Master''''s degree preferred.
Experience: Three to five years of relevant experience in healthcare, analytics, or informatics.
Certification/Licensure: N/A
Software/Hardware: MS Office, SQL/SAS, Qlik, Tableau and/or other query/analytic tools.

(4) Medicaid Behavioral Health Services Manager |

The Children's Village | LinkedIn

SourceURL: https://www.linkedin.com/jobs/view/medicaid-behavioral-health-services-manager-at-the-children%27s-village-1152111914/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Medicaid Behavioral Health Services Manager

Company Name The Children's Village
Company Location Dobbs Ferry, NY, US

New Posted Date Posted 8 hours ago Number of applicants Be among the first 25 applicants

Description

Position Overview: The Medicaid Behavioral Health Services Manager is responsible for the coordination and oversight of outpatient behavioral health services authorized under Child and Family Treatment and Support Services (CFTSS) and Home and Community Based Services (HCBS). The MBHS Manager ensures that providers are appropriately credentialed and supervised, that services are delivered to eligible clients as part of an approved plan of care, and that services are documented and billed in a manner that is compliant with all applicable regulations, contracts, and best practices. The MBHS Manager provides subject matter expertise across the agency's programs regarding eligibility, service definitions, billing and documentation requirements, managed care benefits and authorizations, and Medicaid compliance, and works to develop new MBHS delivery options and referral sources to the benefit of clients and their families.
Position Qualifications: Bachelor's degree with at least five years' experience in Medicaid health or behavioral health services, oversight, or compliance OR Master's degree with at least two years' experience. Knowledge of NY State Medicaid benefits, including foster care per diems, waiver programs, or other behavioral health services preferred. Ability to interpret and understand new Medicaid services and policies and develop and implement program models in

response. Strong organization and tracking skills to monitor compliance, billing and regulatory requirements. Knowledge or experience with the use of myEvolv (or similar electronic health records) for outpatient behavioral health documentation and billing preferred.

(4) Director- Value Transformation Medicaid Health - Professional Hourly Multiple locations | Navigant | LinkedIn

SourceURL: https://www.linkedin.com/jobs/view/director-value-transformation-medicaid-health-professional-hourly-multiple-locations-at-navigant-1150420963/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Director- Value Transformation Medicaid Health - Professional Hourly Multiple locations

---

Company Name Navigant Company Location Minneapolis, MN, US

Posted Date Posted 1 day ago Number of applicants Be among the first 25 applicants

Navigant Consulting, Inc. (NYSE: NCI) is a specialized, global professional services firm that helps clients take control of their future. Navigant's professionals apply deep industry knowledge, substantive technical

expertise, and an enterprising approach to help clients build, manage and/or protect their business interests. With a focus on markets and clients facing transformational change and significant regulatory or legal pressures, the Firm primarily serves clients in the healthcare, energy and financial services industries. Across a range of advisory, consulting, outsourcing, and technology/analytics services, Navigant's practitioners bring sharp insight that pinpoints opportunities and delivers powerful results. More information about Navigant can be found at navigant.com.
Navigant's Healthcare Practice strives to be the premier independent management consulting practice assisting senior level healthcare executives deal with their core business challenges. The Navigant Consulting Healthcare Payer practice is based out of three offices: Chicago, Seattle and Washington, DC. Our professionals are experienced in areas of health care policy and program design and implementation, economics, financial and accounting analyses, regulatory systems and information management. Successful candidates may work with our clients to develop, evaluate, and implement new health care delivery and payment systems. Listed below are some of the areas in which our health care professionals provide services:

- Policy design, development and implementation
- Payment methodologies and rate development
- Managed care program design and implementation
- Health care reform
- Findings, assurances and rate studies
- Insurance and claims management
- Healthcare information technology (HIT).
  This role can be based in any of the following locations: Atlanta, GA; Chicago, IL; Denver, CO; Indianapolis, IN; Minneapolis, MN; Seattle, WA Washington, DC
- Performing business analysis and design through industry-based methodologies
- Developing business-based solutions to address business initiatives and problem statements
- Performing financial, accounting, economic, actuarial and/or statistical analyses
- Developing computer models including detailed and complex spreadsheet analyses
- Data compilation and inventory through the process of assessment requests and client interviews
- and
- Aiding team in report creation and presentation, and quality control of all deliverables
- Develop and test business processes, capabilities and architectures and operational transaction activities

- Assist in all engagement administrative functions related to communicating changes in work processes to identify process breakdowns and prioritize issues affecting client performance improvement
- Provide engagement planning, quality review and oversight
- Lead engagement management functions including communication and coordination of work effort of large teams of consultants and client personnel
- Coordinate presentations and work product of Navigant team members
- Gather, analyze and present data, including document review and quality control of data entry activities. Provide strategic and data analysis as needed
- Manage engagement risk, scope, budget and quality
- Staff engagements to ensure ideal mix of team skill sets as well as time/effort commitment. Build cohesive teams
- Participate in staff recruitment, mentoring, development and retention activities
- Support the identification, pursuit and close of new business opportunities both with new clients and follow-on work at existing clients
- Keep up-to-date on trends and regulatory changes and requirements impacting the healthcare industry
- A Master's degree in business, health policy and administration, public policy, public health, actuarial science and/or social service administration
- 15
- years of previous work experience in the health care industry, preferably in a consulting capacity or consulting firm with a strong track record
- Proven track record of consulting revenue generation greater than $2 million/year
- Excellent quantitative analysis skills
- Ability to lead multiple concurrent engagements
- generally 3-5, with project revenue up to $3 million
- Competencies in managed care, rate setting, actuarial services for Medicaid programs or large commercial payers and/or hospitals
- Previous knowledge and experience working with SAS, a plus
- Working knowledge of Word, Excel, PowerPoint, and Access as well as the ability to conduct research through use of the internet and other information sources
- Superior written and oral communication skills
- The ability to work overtime as necessary
- The ability to travel as necessary
- Frequently communicates with clients and coworkers and must be able to share information effectively
- Strong conceptual, as well as quantitative and qualitative analytical skills
- Flexibility and responsiveness in managing multiple projects in sometimes high-pressure situations simultaneously

- Self-motivator with ability to work independently
- Plan, direct, and coordinate work activities of others
- Frequently travels by airplane, train or car as necessary to perform work at another location
  The company offers competitive compensation packages including an incentive compensation plan, comprehensive medical/dental/life insurance, 401(k) and employee stock purchase plans.
- _Navigant does not accept unsolicited resumes through or from search firms or staffing agencies. All unsolicited resumes will be considered the property of Navigant and Navigant will not be obligated to pay a placement fee._**
- Navigant** is an Equal Employment Opportunity / Affirmative Action employer. All qualified applicants will receive consideration for employment without regard to race, color, national origin, ancestry, citizenship status, military status, protected veteran status, religion, creed, physical or mental disability, medical condition, marital status, sex, sexual orientation, gender, gender identity or expression, age, genetic information, or any other basis protected by law, ordinance, or regulation.
  Navigant will consider for employment qualified applicants with criminal histories in a manner consistent with the requirements of applicable law or ordinance including the Fair Chance Ordinance of Los Angeles and San Francisco.

(4) Health Care Business Analyst(Medicaid & MMIS)(Job ID:WISCJP00014393) | Computer Consultants Group, Inc. | LinkedIn

SourceURL: https://www.linkedin.com/jobs/view/health-care-business-analyst%28medicaid-%26-mmis%29%28job-id%3Awiscjp00014393%29-at-computer-consultants-group%2C-inc.-1151011034/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Health Care Business Analyst(Medicaid & MMIS)(Job ID:WISCJP00014393)

Company Name Computer Consultants Group, Inc. Company Location Madison, WI, US

Posted Date Posted 1 day ago Number of applicants Be among the first 25 applicants

Job Description Reviews, analyzes, and evaluates business systems and user needs. Formulates systems to parallel overall business strategies. Experienced with business process reengineering and identifying new applications of technology to business problems to make business more effective. Familiar with industry standards, current and emerging technologies, and business process mapping, and reengineering. Prepares solution options, risk identification, and financial analyses such as cost/benefit, ROI, buy/build, etc. Develops RFPs. Business Analyst/Consultant capabilities with 8 or more years of experience in the field or in a related area. Relies on experience and judgment to plan and accomplish goals. Independently, performs a variety of complicated tasks. A wide degree of creativity and latitude is expected.

Services to be performed include acting as business analyst to facilitate, elicit, document, validate, and test the business requirements for the takeover and enhancement of the Medicaid Management Information System (MMIS) and fiscal agent contract.

- General skills and experience:
- Excellent interpersonal communication skills
- Excellent organization and time management skills
- Providing detailed status report updates to Project Manager
- Experienced with business process reengineering and identifying new applications of technology to business problems to make business more

effective
- Experience with business analyst and testing industry standards, current and emerging technologies, business process mapping, and reengineering
- Business analyst skills and experience:
- Facilitation
- Efficiently plan and execute meetings
- Establish agenda and set meeting objectives
- Document and distribute meeting decisions and action items
- Timely follow-up on all action items
- Document issues and providing to Project Manager
- Formulate systems to parallel overall business strategies
- Prepare Risk Identification
- Prepare Fiscal Analysis (i.e. cost/benefit, ROI, buy/build)
- Relies on experience and judgment to plan and accomplish goals. Independently, performs a variety of complicated tasks. A wide degree of creativity and latitude is expected.
- Elicitation
- Efficiently and effectively divine business requirements from business area staff
- Documentation
- Use established business requirement templates
- Produce clear and concise requirements documentation
- Create traceability to RFP requirements
- Validation
- Effectively and efficiently review and validate documented business requirements with business area staff and owners
- Review, analyze, and evaluate business systems and user needs
- Testing
- Document clear test plans and create test cases that are traceable to business, functional, non-functional, and transition requirements
- Effectively and efficiently executes test plan and document test results
- Document defects and collaborates with other business analysts and developers to resolve and execute regression testing
- Facilitate review of test results with project stakeholders
- Industry skills and experience
- 3 to 5 years of experience performing a business analyst role supporting State Medicaid and MMIS, or similar health care business and system in one or more of the following functional areas:
- Provider management
- Member (recipient) eligibility and enrollment
- Claims and encounters
- Benefit plan administration
- Service authorization
- Financial services

- Decision support system/data warehouse
- Pharmacy benefit management
- Program integrity and utilization management
  Certified Business Analysis Professional (CABP) preferred

(4) Supervisory Physician. | Centers for Medicare & Medicaid Services | LinkedIn

SourceURL: https://www.linkedin.com/jobs/view/supervisory-physician.-at-centers-for-medicare-%26-medicaid-services-1152029256/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Centers for Medicare & Medicaid Services

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 GP-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 GP-14 grade level in the Federal government, obtained in either the private or public sector, to include: (1) Providing medical authoritative direction in the development of evidence-based Medicare coverage

policies; (2) Directing the assessment of new and emerging health care technologies related to drugs, devices, and medical/surgical procedures; and (3) Directing staff in the evaluation of clinical and coverage issues (including but not limited to physician and ambulatory care, preventive care, clinical laboratories, drugs and biologicals, diagnostic imaging, durable medical equipment, and medical devices and prosthetics) to develop agency recommendations.

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.

Education

Education Requirement: In addition to meeting the qualification requirements, all candidates must have the following educational requirements:

Degree: Doctor of Medicine, Doctor of Osteopathic Medicine or equivalent from a school in the United States or Canada. This degree must have been accredited by the Council on Medical Education of the American Medical Association (external link); Association of American Medical Colleges; Liaison Committee on Medical Education; Commission on Osteopathic College Accreditation of the American Osteopathic Association, or an accrediting body recognized by the U.S. Department of Education at the time the degree was obtained.

Degree from Foreign Medical School: A Doctor of Medicine or equivalent degree from a foreign medical school must provide education and medical knowledge equivalent to accredited schools in the United States. Evidence of equivalency to accredited schools in the United States is demonstrated by permanent certification by the Educational Commission for Foreign Medical Graduates (external link), a fifth pathway certificate for Americans who completed premedical education in the United States and graduate education in a foreign country, or successful completion of the U.S. Medical Licensing Examination.

AND

1 year of supervised experience providing direct service in a clinical setting, i.e., a 1-year internship or the first year of a residency program in a hospital or an institution accredited for such training.

AND

5 years of graduate training in the specialty of the position to be filled or equivalent experience and training.

Evaluation of Candidates

Interviews: Applicants may be interviewed to assure that they possess the degree of skill in interpersonal relationships required for satisfactory performance of the duties of the position to be filled.

Substitution of Experience for Residency Training: Experience may not be substituted for residency training that is essential for the performance of specialized duties. For example, specialists such as psychiatrists and surgeons must complete the number of years of accredited residency training required in their respective specialties. An exception may be made when a peer panel of physicians (subject-matter experts) determines and documents that the knowledge, skills, and abilities acquired in professional medical practice are equivalent to those acquired during the same period of time in a graduate training program.

Teaching Experience: Graduate teaching experience as a member of the faculty in a school of medicine or school of public health may be credited for training positions or as appropriate for specialist positions. (Teaching undertaken as a part of a residency or fellowship training does not satisfy this requirement.

Board Certification: Candidates must be Board certified in a recognized medical specialty. YOU MUST ATTACH PROOF OF THIS

License/Registration Requirement: In addition to meeting the qualification requirements, all candidates must possess the following license/registration:In addition to meeting the qualification requirements, all candidates must possess the following license/registration:A current, active, full, and unrestricted license or registration as a Physician from a State, the District of Columbia, the Commonwealth of Puerto Rico, or a territory of the United States.

Proof of Licensure/Registration is required at the time of application to verify possession of the license/registration listed above. Please see the "Required Documents" section below for more information.

Click The Following Link To View The Occupational Questionnaire

Additional information

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

In addition to normal salary, when applicable requirements are met, Physician and Dentist Pay (PDP) will be authorized.

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.

Traditional rating and ranking of applications does not apply to this vacancy. Applications will be evaluated against the basic qualifications. Qualified candidates will be referred for consideration in accordance with the

Background checks and security clearance

Security clearance

Drug test required

No

(4) Medicaid Eligibility Specialist | Tri-County Care CCO | LinkedIn

SourceURL: https://www.linkedin.com/jobs/view/medicaid-eligibility-specialist-at-tri-county-care-cco-937327557/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Medicaid Eligibility Specialist

Company Name Tri-County Care CCO
Company Location Monsey, New York

Posted Date Posted 2 days ago Number of applicants Be among the first 25 applicants

Tri County Care, a newly formed Care Coordination Organization (CCO), provides Care Management and Coordination services tailored specifically to support people with I/DD and their families. Tri-County Care brings together health care and developmental disability service providers to develop an integrated, comprehensive care plan.

We are actively seeking to hire a **Medicaid Eligibility Specialist** to join our team. Candidate will perform all duties related to enrollment of Medicaid beneficiaries.

Responsibilities include:

- Providing education to the potential individuals regarding the Medicaid process, and determine Medicaid eligibility
- Assisting individuals with the Medicaid application process including home visits when necessary and follow-up communication with local DSS offices
- Facilitate compilation of all required documents to be submitted to the local County within specified time-frame to assure Medicaid coverage for individual
- Track and follow the Medicaid status for all new enrollees
- Revalidate individuals Medicaid benefit when current Medicaid participant's coverage expires

Qualifications:

- Minimum 3 years of experience with Medicaid Eligibility Procedures

Tri-County Care offers competitive pay and great benefits.

In addition to the personal satisfaction and purpose that our employees feel, they receive a competitive compensation and generous benefit package that addresses vacation, health as well as financial needs: Medical, Dental and Vision Coverage company-paid Life Insurance, Long-Term Disability Insurance, and Paid Time Off.

Tri-County Care is fully committed to Equal Employment Opportunity and to attracting, retaining, developing and promoting the most qualified employees without regard to their race, gender, color, religion, sexual orientation, national origin, age, physical or mental disability, citizenship status, veteran status, or any other characteristic prohibited by state or local law.

MVP Health Care REPRESENTATIVE, CARE CENTER MEDICAID Job in Tarrytown, NY

SourceURL: https://www.glassdoor.com/job-listing/representative-care-center-medicaid-mvp-health-care-JV_IC1132438_KO0,35_KE36,51.htm?

jl=2902225724&utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

REPRESENTATIVE, CARE CENTER MEDICAID

3.4 MVP Health Care – Tarrytown, NY 2 days ago
Applied 3/4/19
Apply on Company Site

2 days ago

New

Get ahead of others. Apply now.

Job

Company

Rating

Salary

Reviews

Benefits
Provides optimum customer service as required to maintain existing members and prevent cancellations. The Care Center Representative must take full responsibility for every call to ensure callers concerns are met. Provides world class customer care to internal and external customers while consistently adhering to all call handling objectives, i.e. hold time, talk time, after call work, schedule adhere and quality assurance. Correctly responds to all Department of Health audit calls on a consistent basis. Acts as a liaison between our internal and external customers. Responds promptly, accurately and effectively to all calls in a polite and professional manner. Responds to all calls timely and have a clear understanding of call avoidance, such as but not limited to: short calls, intentional disconnects, inappropriate transfers and inappropriate use of hold button. Performs data input in a highly accurate and timely manner on all customer

contacts. Simultaneously accesses multiple databases while addressing customer's needs. Researches information needed to accurately respond to customers concerns. Asks appropriate questions to ensure a clear understanding of customers concern. Clearly explains all policies and procedures on both incoming and out-going calls. On an ongoing basis, educates members about their benefits and Hudson's procedures. Develops a comprehensive understanding of all lines of business. Has the technical skills required to be able to perform task efficiently. Delivers information in a clear and confident manner. Performs other duties as assigned.

POSITION QUALIFICATIONS

Minimum Education:

High School diploma or equivalent when possesses customer service employment experience.

Post high school education (Associates degree, college courses) preferred

Minimum Experience:

Minimum 1 – 3 years customer service experience and/or relevant office experience required

Experience in positions where adherence to strict confidentiality is required

Healthcare, health insurance experience preferred Call Center experience preferred

Required Skills:

•Must be bilingual (Spanish speaking)

•Strong problem solving skills with effective oral and written communication skills.

•Have strong interpersonal skills and exhibit good judgment.

•Demonstrated excellent customer service skills including superior accountability and follow through

•Demonstrated PC skills using Microsoft applications

Preferred Skills:

- Excellent telephone/communication skills