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Medicaid Jobs Hunter

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10. Network Manager CA Medicaid Health Plan | Aetna, a CVS Health Company | LinkedIn

MEDICAL/HEALTH CARE PROGRAM ANALYST - 68053427 | State of Florida | LinkedIn

SourceURL: https://www.linkedin.com/jobs/view/medical-health-care-program-analyst-68053427-at-state-of-florida-1161099723/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic
Author: sarai209

MEDICAL/HEALTH CARE PROGRAM ANALYST - 68053427

State of Florida Company Location

New Posted Date Be among the first 25 applicants

RequisitionNo: 50127

Agency: Agency for HealthCare Administration

Working Title: MEDICAL/HEALTHCARE PROGRAM ANALYST - 68053427

PositionNumber: 68053427

Salary: $1,574.93 / Bi-Weekly

Posting Closing Date:03/19/2018

This is an exciting opportunity to help shape thequality of health care in Florida. The Agency for Health CareAdministration (AHCA) is the State of Florida agency responsiblefor oversight of the Medicaid program. The Medicaidprogram provides low-income families and individuals with access tohealth care. If you have a desire to use your talent andskills at an organization that provides critical services tomillions of individuals and families across the state, AHCA invitesyou to apply to become an essential member of our team. As one ofFlorida's leading state agencies, AHCA'sdiverse workforce community of more than 1,400 employees is proudof its efforts to serve the people of Florida.

We are seeking to hire a Medical Health Care Program Analystwho desires to work to enhance the delivery of health care servicesthrough the Florida Medicaid Program. This positionrequires a candidate who is creative, flexible, innovative, and whowill thrive in a fast-paced, team based work environment.

This position is located in the Bureau of MedicaidPlan Management Operations (PMO). PMO is responsible for theprimary oversight of Medicaid's managed care programs,with a focus on the Statewide Medicaid Managed Care (SMMC) program.The bureau's primary responsibility is ensuring that themanaged care plans meet Medicaid contractual requirements,including the timely provision of medically needed services andprovider payment for such services.

Thishighly professional and technical position is located in theCompliance Coordination Unit (CCU). The CCU is responsible forcoordination and standardization of compliance related activitiesacross the Agency, as well as being responsible for conductingcontract monitoring. The person in this position serves as a teammember who conducts contract monitoring activities to ensuremultiple Fortune 500 health plans who have contracted with AHCA toprovide Medicaid services for the Statewide Medicaid Managed CareProgram are in compliance with contractual requirements.

Some Examples Of Work Include

- Coordinating, implementing andmonitoring of SMMC plan management compliance coordinationactivities.
- Reviewing andanalyzing reports submitted by managed care plans to determine plancompliance.
- Conducting programevaluations, and conducting work simplifications.
- Providing technical assistance tomanaged care plans.
- Developingcompliance related operational processes and procedures.

AHCA Offers An Excellent Array Of Benefits,including

- Healthinsurance
- Lifeinsurance
- Dental, vision and supplementalinsurance
- Retirementbenefits
- Vacation and sickleave
- Paidholidays
- Opportunities for careeradvancement
- Tuition waiver for public collegecourses
- Trainingopportunities

This position may require travel.

For more information about the Bureau ofPlan Management Operations, please visit our website athttp://ahca.myflorida.com/Medicaid/index.shtml.

Join us at the Agency for Health Care Administration infulfilling our mission to provide "Better Health Care forallFloridians".

Knowledge, Skills,andabilities

- Knowledge of methods necessary forefficient compiling, organization and analyzingdata;
- Knowledge of, and experience with, wordprocessing, spreadsheet and/or database software asrequired;
- Knowledge of system integrations, design,development, testing andimplementation;
- Knowledge of system security and thesecure electronic transfer ofinformation/data;
- Ability to direct/coordinate the planningand implementation of operational/program reviews and monitoringactivities;
- Ability to interpret and apply contractrequirements, statutes, rules, regulations, policies andprocedures;
- Ability to communicate effectively, bothverbally and inwriting;
- Ability to work cooperatively as a memberof the team;
- Ability to determine work priorities andensure proper completion of work assignments in a timelymanner;
- Ability to collect, analyze and evaluatedata quickly and accurately, develop reports, and makerecommendations;
- Ability to apply state procurement lawsand contract managementpolicies/procedures;
- Ability to present information to otherswho possess varying levels of knowledge related to complextopics/initiatives/technicalinformation.
- Ability to travel with or withoutaccommodations.

Minimumqualificationsrequirements

- Atleast 2 years of experience coordinating, planning and implementingoperational reviews and conducting program compliancemonitoring.
- Atleast 2 years of experience conducting data analysis and developingreports.
- Atleast 2 years of experience developing operational processes andprocedures.
- Atleast 2 years of experience working with MicrosoftExcel.
- Abachelor's degree from a college or university is preferredwith two additional years of professional experience in dataanalysis, program monitoring, developing processes and procedures.A master's degree from a college or university cansubstitute on a year-for-year basis for the preferred degree andexperience.

CONTACT:SARAH M. JAMES850-412-4032

The Stateof Florida is an Equal Opportunity Employer/Affirmative ActionEmployer, and does not tolerate discrimination or violence in theworkplace.

Candidates requiring a reasonableaccommodation, as defined by the Americans with Disabilities Act,must notify the agency hiring authority and/or People First ServiceCenter (1-866-663-4735). Notification to the hiring authority mustbe made in advance to allow sufficient time to provide theaccommodation.

The State of Florida supports aDrug-Free workplace. All employees are subject to reasonablesuspicion drug testing in accordance with Section 112.0455, F.S.,Drug-Free Workplace Act.

VETERANS'PREFERENCE. Pursuant to Chapter 295, FloridaStatutes, candidates eligible for Veterans' Preference willreceive preference in employment for Career Service vacancies andare encouraged to apply. Candidates claiming Veterans'Preference must attach supporting documentation with eachsubmission that includes character of service (for example, DD Form214 Member Copy #4) along with any other documentation as requiredby Rule 55A-7, Florida Administrative Code. Veterans'Preference documentation requirements are available by clickinghere. All documentation is due by the close of the vacancyannouncement.

Nurse Practitioner, Field (Saginaw, MI) | Molina Healthcare | LinkedIn

SourceURL: https://www.linkedin.com/jobs/view/nurse-practitioner-field-saginaw-mi-at-molina-healthcare-1155842975/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic
Author: sarai209

Nurse Practitioner, Field (Saginaw, MI)

Molina Healthcare Company Location

Posted Date Be among the first 25 applicants

Description

Molina Healthcare has always been a special place to work. Founded by Dr. C. David Molina 35 years ago, the company has grown over the past few decades from a single clinic to health plans serving fifteen states. During the time of expansion we have never lost sight of the mission that defines us; to serve the most financially vulnerable members of our society with dignity and respect. Our goal is to ensure "that everyone has access to quality healthcare."

Vitalis/Care Connections, our national team of Nurse Practitioners, provides in home health services for Medicare, Marketplace, and Medicaid recipients. Through our program we are able to meet our patients where they live and conduct health assessments in the privacy and comfort of their home.

By utilizing Epic, our customized electronic health record, as well as advanced point-of-care testing equipment, we are able to provide our patients with a thorough and comprehensive health care experience. We use technology to strategically schedule visits with the aim of maximizing patient care time while decreasing the time spent driving from home to home. Visits vary from preventive care for diabetics, to post-partum assessments, and annual comprehensive

exams to make sure our health plans receive a complete and accurate picture of our patients' health conditions and needs.

We are looking for Family Nurse Practitioners who are committed to caring for those who are often overlooked and under-served in our society. As the next generation of delivery models unfold, this is an opportunity to join a progressive organization that has never lost sight of the mission of meeting the medical, psychological and social needs of each patient. As a result, this strengthens the communities we serve and delivers superior outcomes.

ABOUT US: Molina Healthcare, a FORTUNE 500, managed care organization, arranges for the delivery of health care services and offers health information management solutions to nearly five million individuals and families who receive their care through Medicaid, Medicare and other government-funded programs in fifteen states.

As a Nurse Practitioner You Will

► Complete a comprehensive review and assessment of patients' medical history, current medications, psycho-social well-being and social determinants of health

► Document progress notes that support comprehensive capture of all active diagnoses

► Provide incomplete preventive care services as determined by HEDIS or Medicare 5 Star requirements

► Perform point-of-care lab and diagnostic testing, such as Hemoglobin A1C, monofilament, nephropathy screening and diabetic retinal exams

► Follow-up on abnormal results and coordinate ongoing care with PCP

► Write prescriptions with the support and oversight of a collaborating physician

► Help at-risk patients transition from the hospital and other facilities to their own home through in-person assessments, post discharge medication reconciliation, referrals and care coordination with the PCP.

Minimum Requirements

► Board certified as an Advanced Nurse Practitioner in the specialty area of family medicine

► Hold an active, unrestricted state Nurse Practitioner license, as well as DEA and NPI number

► Have a current provider card in Basic Life Support (BLS)

► Comfortable walking up flights of stairs while carrying up to 50 lbs. of equipment, as some residences may not have elevators

Ideal Candidates Have

► A passion to serve the underserved

► Previous experience working with Medicaid, Marketplace and Medicare populations

► At least 3 years of clinical experience preferably in home health, palliative care and/or hospice settings

► Epic EHR experience

► Bilingual or multi-lingual communication skills

You Will Love This Job If

► You consider yourself a self-starter and enjoy being outside of the four walls of a clinic or hospital

► You consider yourself an innovator and would like to participate in pilots for new services or care models

► You are tech savvy and want to learn more about Clinical Informatics or Health Information Technology

► You are a new graduate looking for a fulfilling entry into the world of healthcare

WHAT'S IN IT FOR YOU?

Benefits

► Competitive financial compensation including generous health insurance benefits

► Work life balance with a fixed productivity goals and no call requirements

► Sign on bonus

► Student loan repayment program

► A continuous learning environment that includes tuition reimbursement

► Walking the talk: Molina's commitment to community includes 16 hours of paid volunteer time off!

► Generous retirement program

► Employee Stock Purchase Program

► Home office stipend, mileage reimbursement and cell phone

We are an equal opportunity employer and value diversity at Molina Healthcare. We do not discriminate on the basis of race, religion, color, national origin, gender, sexual orientation, age, martial status, veteran status, or disability status.

Required Education

Job Qualifications

- Master's degree in nursing from an accredited nursing program

Required Experience

- Previous experience as a licensed clinician providing care in a home health setting
- 0-3 Years as Nurse Practitioner
- Minimum 3 years clinical experience

Required License, Certification, Association

- Completion of Nurse Practitioner program at the Master's level with certification
- Current state-issued license to practice as a Nurse Practitioner
- Must meet credentialing requirements established for nurse practitioners (Master's Degree in Nursing and National Certification from one of the following organizations:

American Academy of Nurse Practitioners; American Credentialing Center; National Certification Corporation for Obstetric, Gynecologic and Neonatal Nursing Specialties; National Certification Board of Pediatric Nurse Practitioners and Nurses.)

Preferred Education

- Master's degree major in gerontology or behavioral health

Preferred Experience

- Previous experience as Nurse Practitioner, 5+ Years
- Extensive home health experience with low income populations, especially in management of chronic conditions
- Bilingual and bicultural

To all current Molina employees: If you are interested in applying for this position, please apply through the intranet job listing.

Molina Healthcare offers a competitive benefits and compensation package. Molina Healthcare is an Equal Opportunity Employer (EOE) M/F/D/V.

To learn more about Molina Healthcare Careers, follow us on LinkedIn , Twitter & Facebook . You can also visit Molina Cares to view interactive tutorials on resume & cover letter writing, interviewing and more!

Primary Location

US-MI-Flint-MIFLINT

Job

Fusion

Organization

Health Plans

Job Posting

Mar 5, 2019, 3:00:43 PM

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-1160101249/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic
Author: sarai209

Medicaid Behavioral Health Services Manager

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

Posted Date Posted 1 day 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.

Seniority Level

Associate

Industry

- Non-profit Organization Management
- Individual & Family Services
- Mental Health Care

Employment Type

Full-time

Job Functions

- Customer Service
- Information Technology

Branch Business Manager (medicaid Pas) | Outreach Health Services | LinkedIn

Branch Business Manager (medicaid Pas)

Outreach Health Services Company Location

Posted Date Be among the first 25 applicants

- $40,000
- $90,000 a year
- We are looking for an ambitious Business Manager to help develop our Houston area.Our company is evolving, and we are looking for people who want to grow with us! If you are tired of being told it can't be done, then join us as we develop exciting new products and services.Home care services have not fundamentally changed in the last 40 years. We believe our company needs to evolve into a new integrated care model and play an active part in the healthcare continuum.Do you want to challenge the status quo? Are tired of box-checking regulations that value compliance over quality and outcomes? With us, you will not be limited by your imagination; only by your willingness to take positive action.If you to have the discipline to be the best, never accept average, and are always looking to disrupt/improve conventional ways of doing things, you will fit into our team.Transparency and accountability are our business mantra
- understand what that means.If the big office and status is important to you
- don't apply
- you won't be happy on our team.ABOUT THE JOB:
- We need a new Business Manager at our current home care company (40 years strong!) who is willing to be at the forefront of a journey to lead an integrated services division in the Houston market. You will build the business plan for the office and show you have a commercial understanding of how your business unit works. You must focus on strategic planning to grow the area.Show us that you understand that technology is our future!... However, at our heart, we are a people business (technology is just the enabler) so you must be a people person. If you love paper, you will hate our business because we are looking to automate everything.Build the relationships to grow your business and show you understand the importance of those relationships. Provide the leadership to the office
- know when you have to roll up your sleeves and lead by example and know when you need to get out of the weeds. Have the people skills to manage your team (everybody in the branch reports into this role) and show you can understand how to recognize and develop potential. You will be transparent and accountable on a business and personal level to your team and the company.SKILLS:
- A hunger for change and growth. Passionate about working as a team. Desire to create new and innovate ways of dealing with problems. Not afraid to be a leader. Embrace Technology
- we don't mind teaching you, but only if you see the potential and are hungry to learn. Team player who accepts help and ideas from outside sources. Exceptional problem-solving skills, multi-tasker under pressure. Work ethically
- Being "right" does not matter, doing "the right thing every time" is what is important.REQUIREMENTS:
- You need to know this market. You have to understand Medicaid PAS programs and the complexity around them. If you have never worked with these programs you will not be able to run in this role unfortunately. Show us you have the inside knowledge of the market and the understanding of how to manage and build this business. Formal education is not that important, but a track record of achievement and hunger is

everything. You must be eligible to work in the U.S. and maintain a passing federal/state background.Salary: $40,000.00 to $90,000.00 /yearExperience:health business management: 5 years (Required)Medicaid home health: 5 years (Required)Work authorization:United States (Required)Additional Compensation:BonusesBenefits offered:Paid time offParental leaveHealth insuranceDental insuranceHealthcare spending or reimbursement accounts such as HSAs or FSAsOther types of insuranceRetirement benefits or accountsCommuting/travel assistanceFlexible schedulesWorkplace perks such as food/coffee and flexible work schedulesOthersPay frequency:Every other weekShift:Day

Behavioral Health Medical Director - Louisiana Medicaid | Humana | LinkedIn

SourceURL: https://www.linkedin.com/jobs/view/behavioral-health-medical-director-louisiana-medicaid-at-humana-1160728895/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic
Author: sarai209

Behavioral Health Medical Director - Louisiana Medicaid

Humana Company Location

Posted Date Be among the first 25 applicants

Description

The Medical Director relies on medical background and reviews health claims. The Medical Director work assignments involve moderately complex to complex issues where the analysis of situations or data requires an in-depth evaluation of variable factors.

Responsibilities

Humana's Louisiana Medicaid BH Medical Director will oversee our behavioral health (BH) clinical program for Louisiana Medicaid plan members. They will collaborate closely with the Chief Medical Officer (CMO) to integrate the day-to-day administration and strategic management of behavioral and physical health services, including utilization management (UM), quality improvement, and value-based payment programs. The BH Medical Director will be based in Louisiana and will also lead the development of new products and services in Humana's Medicaid BH delivery model.

Essential Functions And Responsibilities

- Lead major clinical and quality management components of Humana's BH services
- Provide clinical case management consultations and clinical guidance for contracted primary care physicians (PCPs) treating BH-related concerns not requiring referral to BH specialists
- Develop comprehensive care programs for the management of youth and adult BH concerns typically treated by PCPs (such as ADHD and depression)

- Oversee, monitor and assist with effective implementation of the Quality Management (QM) program; accountable for overall continuous improvement of BH services and programs
- Oversee, monitor, and assist with the management of psychopharmacology pharmacy benefits manager (PBM) activities, including the establishment of prior authorization, clinical appropriateness of use, and step therapy requirements for the use of stimulants and antipsychotics for all enrollees under age 18
- Work closely with the UM of services and associated appeals related to children and youth and adults with mental illness and/or substance use disorders (SUD)
- Develop targeted education and training for Humana PCPs to screen for mental health and SUD using evidence-based tools (e.g. AUDIT-C, PHQ-9, and GAD-7), perform diagnostic assessments, provide counseling and prescribe pharmacotherapy when indicated, and build collaborative care models in their practices
- Lead BH policy development in Louisiana, driving implementation, oversight, and accountability for both Humana internal and external stakeholders
- Adhere to and comply with federal and state laws and programmatic requirements
- Collaborate with provider relations personnel to ensure high-quality and appropriate care delivered through the BH provider network
- Establish and maintain relationships with providers, advocates, and other key Louisiana stakeholders by maintaining open and ongoing communications; represent Humana at public forums and engagement opportunities
- Maintain compliance with BH-related contract requirements and attend oversight committee meetings to ensure appropriate procedures are adhered to within Humana and within care delivery
- Collaborate closely with corporate and local population health teams in developing programs and strategies to address BH needs at a population health level
- Share responsibility for the management of the BH services delivery system with the BH Coordinator and Addictionologist/Addiction Services Manager
- Serve as co-chairperson of Humana's Louisiana Quality Improvement Committee

Required Education, Certification, & Experience Qualifications

- Physician with a current, unencumbered Louisiana-license as a physician
- Board-certified in psychiatry
- At least three (3) years of training in a medical specialty
- Knowledge of the managed care industry
- Possess analysis and interpretation skills with prior experience leading teams focusing on quality management, UM, discharge planning and/or home health or rehab

Preferred Experience Qualifications

- Five (5) years or more clinical experience working in BH
- Familiarity with Louisiana-based BH organizations
- Medicaid Managed Care clinical or behavioral health leadership experience

Scheduled Weekly Hours
40

CHC Service Coordinator | UPMC Health Plan | LinkedIn

SourceURL: https://www.linkedin.com/jobs/view/chc-service-coordinator-at-upmc-health-plan-1161194303/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Author: sarai209

(2) CHC Service Coordinator

Description

Community HealthChoices (CHC) is Pennsylvania's managed care long term services and supports (LTSS) program serving seniors and individuals with physical disabilities in the Commonwealth, as well as dual-eligible individuals covered by Medicare and Medicaid.

To provide service coordination services across the continuum of care through a community-based approach to improve health outcomes of the Members served. Service coordination's purpose is a for a collaborative process that assesses, plans, implements coordinates, monitors and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes.

Responsibilities

- Actively coordinates with other individuals and entities essential in the physical and behavioral care delivery for the Member to provide for seamless coordination between physical, behavioral and support services
- Assist Members in obtaining HCBS services that will support independent living
- Assist the Member and his or her PCPT in identifying and choosing willing and qualified Providers
- Collect s additional necessary information, including, at a minimum: Member preferences, strengths and goals to inform the development of the PCSP Conducts reevaluation of level of care annually or more frequently as needed
- Explores coverage of services to address Member identified needs through other sources, including services provided under Medical Assistance , Medicare or private insurance and other community resources
- Identify, coordinate and assist Members in gaining access to needed LTSS and Medical Assistance services, as well as non-Medicaid funded medical, social, housing, educational, and other services and supports
- Informing Members about available LTSS, required assessments, the Person t-centered service planning process, service alternatives, service delivery options including opportunities for Self -direction, roles, rights including DHS Fair Hearing rights, risks and responsibilities, and to assist with fair hearing requests when needed and requested, and to protect a Members health, welfare and quality on on-going basis
- Lead the Person-Centered Service Planning (PCSP) process and oversee the implementation of PCSPs
- Providing information to Members and facilitating access, coordinating and monitoring LTSS needs for Members
- Works with the Member to complete activities necessary to maintain LTSS eligibility

Qualifications

- Bachelor's degree in Social Work, Psychology, or other related fields.
- At least three years working in social service or health care related setting; Completion of person-centered planning and person-centered direction training; Experience working with people with disabilities or seniors in need of LTSS; Knowledge of the home and community-based service system and how to access and arrange for services;
- Experience conducting LTSS needs assessments and monitoring LTSS delivery;
- Cultural competency and the ability to provide informed advocacy;
- Ability to interact with physicians and other health care professionals in a professional manner is required

Licensure, Certifications, and Clearances:

- Driver's License

Medicaid Eligibility Advocate | HCA Healthcare | LinkedIn

SourceURL: https://www.linkedin.com/jobs/view/medicaid-eligibility-advocate-at-hca-healthcare-1143451488/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic
Author: sarai209

Medicaid Eligibility Advocate

HCA Healthcare Company Location

New Posted Date Be among the first 25 applicants

Description

SHIFT: Days (rotating weekends)

SCHEDULE: Full-time

Do you have exceptional customer service and the ability to plan organize and exercise sound judgment? Do you have demonstrated communication, problem solving and case management skills and the ability to act/decide accordingly?

Now is the time to join our team of motivated and nurturing individuals working to assist patients with their Medicaid Eligibility screening and enrollment. Ideal candidates will have a steady work knowledge of medical terminology, practices and procedures, as well as laws, regulations, and guidelines. You should also share a passion for our purpose, **"To serve and enable those who care for and improve human life in their community."**

Does this sound like you? If so, APPLY TODAY. See what makes us a **fabulous place to work!**

">

Parallon is now seeking a Full-Time Medicaid Eligibility Advocate

You can also ***Like us on Facebook***: https://www.facebook.com/ParallonRCSJobs.

What We Can Offer You

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

What You Will Do

- Responsible for conducting eligibility screenings, assessment of patient financial requirements, and counseling patients on insurance benefits and co-payments.
- Serve as a liaison between the patient, hospital, and governmental agencies; and you will be actively involved in all areas of case management.
- Screen and evaluate patients for existing insurance coverage, federal and state assistance programs, or hospital charity application.
- Re-verify benefits and obtains authorization and/or referral after treatment plan has been discussed, prior to initiation of treatment. Ensures appropriate signatures are obtained on all necessary forms.
- Obtain legal relevant medical evidence, physician statements and all other documentation required for eligibility determination, and complete and file applications.
- Initiate and maintain proper follow-up with the patient and government agency caseworkers to ensure timely processing and completion of all mandated applications and accompanying documentation.
- Document progress notes to the patient's file and the hospital computer system.
- Participate in ongoing, comprehensive training programs as required.
- Required to make field visits as necessary.

Qualifications

EXPERIENCE AND EDUCATION NEEDED:

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

About Us

Parallon believes that organizations that continuously learn and improve will thrive. That's why after more than a decade we remain dedicated to helping hospitals and hospital systems operate knowledgeably, intelligently, effectively and efficiently in the rapidly evolving healthcare marketplace, today and in the future. As one of the healthcare industry's leading providers of business and operational services, Parallon is uniquely equipped to provide a broad spectrum of customized revenue cycle services.

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

#ParallonBCOM

Program Analyst. | Centers for Medicare & Medicaid Services | LinkedIn

SourceURL: https://www.linkedin.com/jobs/view/program-analyst-at-centers-for-medicare-medicaid-services-147394021/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic
Author: sarai209

Program Analyst.

Centers for Medicare & Medicaid Services Company Location

Posted Date Be among the first 25 applicants

- Duties

  Summary

  This position is located in the Department of Health & Human Services (HHS), Centers for Medicare & Medicaid Services (CMS), Office of Information Technology (OIT), Information Technology Capital Planning Group (ITCPG), Division of IT Investment Management Policy (DIIMP).

  As a Program Analyst, GS-0343-12, you will be performing a variety of complex program analysis utilizing qualitative and quantitative methods to determine organizational program efficiency and effectiveness.

  Responsibilities
    - Analyze and evaluate the efficiency and effectiveness of a health care, health regulatory, or human services or related program, within a CMS organization.
    - Provide technical advice on policies and procedures.
    - Review and evaluate established program policies and procedures to determine gaps where additional guidance is needed.
    - Employs qualitative and quantitative methods, procedures and systems for assessing the efficiency and effectiveness of a health care program, or a segment of a program.
- Travel Required
-
- Not required
-
- 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.
    - Time-in-Grade restrictions apply.
- **Qualifications**
-
- **ALL QUALIFICATION REQUIREMENTS MUST BE MET WITHIN 30 DAYS OF THE CLOSING DATE OF THIS ANNOUNCEMENT.**
-
- **In order to qualify for the GS-12**, you must meet the following: You must demonstrate in your resume at least one year (52 weeks) of qualifying specialized experience equivalent to the GS-11 grade level in the Federal government, obtained in either the private or public sector, to include: 1) Analyzing and evaluating the efficiency and effectiveness of program operations within a CMS organization; 2) Formulating and recommending additional policies or procedures or modifications to improve efficiency and effectiveness

of current program operations; and 3) Advising managers and program officials on management or program-related policies and procedures.

- **Substitution of Education for Experience: There is no substitution of education to meet the specialized experience requirement at the GS-12 grade level.**
- **Combination of Experience and Education: There is no combination of experience and education to meet the specialized experience requirement at the GS-12 grade level.**
- Experience refers to paid and unpaid experience, including volunteer work done through National Service programs (e.g., Peace Corps, AmeriCorps) and other organizations (e.g., professional; philanthropic; religious; spiritual; community, student, social). Volunteer work helps build critical competencies, knowledge, and skills and can provide valuable training and experience that translates directly to paid employment. You will receive credit for all qualifying experience, including volunteer experience.
- **Time-in-Grade:** To be eligible, current 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:** Not Required
- CMS employees currently participating in 100% Full-Time Telework Program may be eligible to remain in the program. If an employee in this program is selected, the pay will be set in accordance with the locality pay for the applicable duty station. The listed salary range reflects the locality pay assigned to the duty location(s) listed in the vacancy announcement. For more information about pay based on locality, please visit the
- **The Interagency Career Transition Assistance Plan (ICTAP) and Career Transition Assistance Plan (CTAP)** provide eligible displaced federal employees with selection priority over other candidates for competitive service vacancies. To be qualified you must submit the required documentation and be rated well-qualified for this vacancy.
- **Additional Forms REQUIRED Prior To Appointment**
    - **Optional Form 306, Declaration of Federal Employment and the Background/Suitability Investigation** - A background and suitability investigation will be required for all selectees. Appointment will be subject to the successful completion of the investigation and favorable adjudication. Failure to successfully meet these requirements may be grounds for appropriate personnel action. In addition, if hired, a reinvestigation or supplemental investigation may be required at a later time. If selected, the Optional Form 306 will be required prior to final job offer.
    - **Form I-9, Employment Verification and the Electronic Eligibility Verification Program** - CMS participates in the Electronic Employment Eligibility Verification Program (E-Verify). E-Verify helps employers determine employment eligibility of

new hires and the validity of their Social Security numbers. If selected, the Form I-9 will be required at the time of in-processing.
    - **Standard Form 61, Appointment Affidavits** - If selected, the Standard Form 61 will be required at the time of in-processing.
- **Additional selections** may be made from this announcement for similar positions within CMS in the same geographical location. For Central Office vacancies, the "same geographical location" includes Baltimore, Maryland; Bethesda, Maryland; and Washington, D.C.
-
- If you are unable to apply online or need to fax a document you do not have in electronic form, view the following link for information regarding an
-
- How You Will Be Evaluated
-
- You will be evaluated for this job based on how well you meet the qualifications above.
-
- Once the announcement has closed, your online application, resume, transcripts and CMS required documents will be used to determine if you meet eligibility and qualification requirements listed on this announcement. If you are found to be among the top qualified candidates, you will be referred to the selecting official for employment consideration. Please follow all instructions carefully. Errors or omissions may affect your rating.
-
  Your qualifications will be evaluated on the following competencies (knowledge, skills, abilities and other characteristics):
    - Project Management
    - Technical Competence
    - Written Communication
- Background checks and security clearance
-
- Security clearance
-
- Drug test required
-
  No
- Required Documents

  <u>The Following Documents Are REQUIRED</u>
- **Resume showing relevant experience; cover letter optional**. Your resume must indicate your citizenship and if you are registered for Selective Service if you are a male born after 12/31/59. Your resume must also list your work experience and education (if applicable) including the start and end dates (mm/dd/yy) of each employment along with the number of hours worked per week. For work in the Federal service, you must include the series and grade level for the position(s). Your resume will be used to validate your responses to the assessment tool(s). For resume and application tips visit:
- **CMS Required Documents (e.g., SF-50, DD-214, SF-15, etc.).** 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.
- **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.

- 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 03/14/2019 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 HRCenterHelpDesk@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
-
- Agency contact information
-
- CMS HR CENTER HELP DESK
-
- Phone
-
- Email
-
- Address
-
- Office of Information Technology
- 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,03/14/2019, you may check your status online by logging into your USAJOBS account (
- Fair & Transparent

  The Federal hiring process is setup to be fair and transparent. Please read the following guidance.

  Equal Employment Opportunity Policy

  The United States Government does not discriminate in employment on the basis of race, color, religion, sex (including pregnancy and gender identity), national origin, political affiliation, sexual orientation, marital status, disability, genetic information, age, membership in an employee organization, retaliation, parental status, military service, or other non-merit factor.

  Reasonable Accommodation Policy

  Federal agencies must provide reasonable accommodation to applicants with disabilities where appropriate. Applicants requiring reasonable accommodation for any part of the application process should follow the instructions in the job opportunity announcement. For any part of the remaining hiring process, applicants should contact the hiring agency

directly. Determinations on requests for reasonable accommodation will be made on a case-by-case basis.

A reasonable accommodation is any change to a job, the work environment, or the way things are usually done that enables an individual with a disability to apply for a job, perform job duties or receive equal access to job benefits.

Under the Rehabilitation Act of 1973, federal agencies must provide reasonable accommodations when:

- An applicant with a disability needs an accommodation to have an equal opportunity to apply for a job.
- An employee with a disability needs an accommodation to perform the essential job duties or to gain access to the workplace.
- An employee with a disability needs an accommodation to receive equal access to benefits, such as details, training, and office-sponsored events.

- You can request a reasonable accommodation at any time during the application or hiring process or while on the job. Requests are considered on a case-by-case basis.
-
- Learn more about
-

  Legal and regulatory guidance

This job originated on

Supervisory Health Insurance Specialist. | Centers for Medicare & Medicaid Services | LinkedIn

SourceURL: https://www.linkedin.com/jobs/view/supervisory-health-insurance-specialist.-at-centers-for-medicare-%26-medicaid-services-147390963/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic
Author: sarai209

Supervisory Health Insurance Specialist.

Centers for Medicare & Medicaid Services Company Location

Posted Date Be among the first 25 applicants

- Duties

  Summary

  This position is located in the Department of Health & Human Services (HHS), Centers for Medicare & Medicaid Services (CMS), Center for Clinical Standards and Quality, Quality Improvement and Innovation Group (QIIG) .

  As a Supervisory Health Insurance Specialist, GS-0107-15, you will serve as Deputy to an SES-level Director, and share authorities and responsibilities with the Director for four of

the five Divisions of QIIG.

Responsibilities

- Serves as the first-level supervisor for four Division Directors.
- Direct the development of policies and provides policy direction, coordination and support of CCSQ's quality improvement services.
- Exercise managerial authority to set long-range goals and objectives, translate objectives into specific projects, determine program emphasis, plan for long-range staffing and organization needs.
- Approve or decides on personnel actions, make selections on key positions, and approves selections made by subordinate supervisors.

- Travel Required
-
- Occasional travel - You may be expected to travel for this position.
-
- Supervisory status
-
- Yes
-
- Promotion Potential
-

None

- 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-15** , you must meet the following: You must demonstrate in your resume at least one year (52 weeks) of qualifying specialized experience equivalent to the GS-14 grade level in the Federal government, obtained in either the private or public sector, to include: 1) Managing projects focused on improving quality improvement and innovation healthcare delivery; 2) Developing strategies to drive quality improvement and innovation in service delivery to improve healthcare delivery; 3) Overseeing work activities of employees or teams to ensure that program operations are met.
-
- 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:** No
- **Tour of Duty:** Flexible
- **Recruitment/Relocation Incentive:** Not Authorized
- **Financial Disclosure:** Required
-
- **The Interagency Career Transition Assistance Plan (ICTAP) and Career Transition Assistance Plan (CTAP)** provide eligible displaced federal employees with selection priority over other candidates for competitive service vacancies. To be qualified you must submit the required documentation and be rated well-qualified for this vacancy.
-
- **Additional Forms REQUIRED Prior To Appointment**
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-
  Your qualifications will be evaluated on the following competencies (knowledge, skills, abilities and other characteristics):
    - Building Coalitions/Communications
    - Business Acumen
    - Leading People
    - Managing Change
- Background checks and security clearance
-
- Security clearance
-
- Drug test required

- No
- Required Documents

The Following Documents Are REQUIRED

- **Resume showing relevant experience; cover letter optional**. Your resume must indicate your citizenship and if you are registered for Selective Service if you are a male born after 12/31/59. Your resume must also list your work experience and education (if applicable) including the start and end dates (mm/dd/yy) of each employment along with the number of hours worked per week. For work in the Federal service, you must include the series and grade level for the position(s). Your resume will be used to validate your responses to the assessment tool(s). For resume and application tips visit:
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    - Supervisor name and phone number
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    - Full-time or part-time status (include hours worked per week)
    - Salary
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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.
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-
- 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 James.jones1@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 James.jones1@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
-
- James Jones
-
- Phone
-
- Email
-
- Address
-
- Center for Clinical Standards and Quality
- 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,03/14/2019, you may check your status online by logging into your USAJOBS account (
- Fair & Transparent

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- An employee with a disability needs an accommodation to perform the essential job duties or to gain access to the workplace.
- An employee with a disability needs an accommodation to receive equal access to benefits, such as details, training, and office-sponsored events.

- You can request a reasonable accommodation at any time during the application or hiring process or while on the job. Requests are considered on a case-by-case basis.
-
- Learn more about
-

  Legal and regulatory guidance

This job originated on

Network Manager CA Medicaid Health Plan | Aetna, a CVS Health Company | LinkedIn

SourceURL: https://www.linkedin.com/jobs/view/network-manager-ca-medicaid-health-plan-at-aetna%2C-a-cvs-health-company-1140489000/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic
Author: sarai209

Network Manager CA Medicaid Health Plan

Company Name Aetna, a CVS Health Company Company Location San Diego, CA, US

Posted Date Posted 4 days ago Number of applicants Be among the first 25 applicants

Job Description

Aetna Better Health of CA is hiring a Network Manager in our San Diego offices.

Our **Network Manager** will design, develop, contract, maintain and enhance relationships with large medical groups, IPAs, hospitals, facilities, physicians and ancillary providers which serve as contractual networks of care for members; foster growth of managed care products. Partner with health plan to determine network and contract needs.
Responsible for reporting, understanding and managing medical cost issues and initiating appropriate action in partnership with health plan.

Fundamental Components

(*) Serves as SME for less experienced team members and internal partners. 15%
(* Provides network development, maintenance, and refinement activities and strategies in support of cross-market network management unit.
(*) Assists with the design, development, management, and or implementation of strategic network configurations and integration activities 20%
(*) Accountable for cost arrangements within defined groups. Collaborates cross-functionally to manage provider compensation and pricing development activities, submission of contractual information, and the review and analysis of reports as part of negotiation and reimbursement modeling activities 15%
(*) Negotiates and executes, conducts high level review and analysis, dispute resolution and/or settlement negotiations of contracts with larger and more complex, market-based, group/system providers.
(*) Manages contract performance and supports the development and implementation of value based contract relationships in support of business strategies. Recruits providers as needed to ensure attainment of network expansion and adequacy targets. 30%
(*) Research and analyze complex healthcare claims, pharmacy and lab data, Perform claim investigations and resolve or escalate for resolution
(*) Establish and/or administer provider reimbursement processes 20 %

BACKGROUND/EXPERIENCE Desired

(*) Must possess a successful track record negotiating large hospital system contracts.
(*) Must have Medi-Cal Contracting ?Policy experience with Physician groups, Ancillary providers and SNF, Home Health and Long Term Support Services
(*) Must have experience working with Providers/IPAs delegated in an IPA Model and shared risk arrangements
(*) Must understand provider enrollment/contracting requirements by specialty.

EDUCATION

(*) The highest level of education desired for candidates in this position is a Bachelor's degree or equivalent experience.

Functional Experiences

Functional - Network Management/Physician recruiting - medical/4-6 Years
Functional - Network Management/Contract negotiation/4-6 Years
Functional - Network Management/Provider data services/4-6 Years
Functional - Network Management/Network market leadership/1-3 Years
Functional - Network Management/Credentialing/1-3 Years

Technology Experiences

Technical - Aetna Applications/Provider Contracts/1-3 Years/End User

Telework Specifications

Option for telework will be evaluated after a certain period of employment
Telework considered only for unique circumstances

Additional Job Information

Highly visible position with opportunity to influence change and make improvements.

Aetna is about more than just doing a job. This is our opportunity to re-shape healthcare for America and across the globe. We are developing solutions to improve the quality and affordability of healthcare. What we do will benefit generations to come.

We care about each other, our customers and our communities. We are inspired to make a difference, and we are committed to integrity and excellence.

Together we will empower people to live healthier lives.

Aetna is an equal opportunity & affirmative action employer. All qualified applicants will receive consideration for employment regardless of personal characteristics or status. We take affirmative action to recruit, select and develop women, people of color, veterans and individuals with disabilities.

We are a company built on excellence. We have a culture that values growth, achievement and diversity and a workplace where your voice can be heard.

Benefit eligibility may vary by position. Click here to review the benefits associated with this position.

Aetna takes our candidates'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.

Req#
57935BR
Job Group
Health Care
EEO Statement
Aetna is an Equal Opportunity, Affirmative Action Employer
Primary Location
CA-San Diego
Additional Locations
CA-San Diego

Percent Of Travel Required

10 - 25%
Potential Telework Position
No
Full or Part Time
Full Time
Supervisory
Yes
Resource Group

Seniority Level

Associate

Industry

- Insurance
- Financial Services
- Hospital & Health Care

Employment Type

Full-time

Job Functions

- Information Technology