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Medicaid Jobs Hunter

1. Organizational Change Manager - Information Technology | Public Consulting Group
2. (5) UAS Nurse - Bronx | Fidelis Care
3. (5) Operations Analyst, Associate Operations Excellence | UPMC Health Plan
4. (5) Medicaid Billing Specialist | VITAS Healthcare
5. (5) Health Insurance Marketplace Navigator | Charlotte Center for Legal Advocacy
6. (5) CHC Service Coordinator RN | UPMC Health Plan
7. Manager, Care Coordination (Medicaid) Denver, CO
8. (5) Medicaid Eligibility Specialist | VillageCare
9. (5) WAVIER MANAGER | Arizona Health Care Cost Containment System (AHCCCS)
10. (5) Health Insurance Specialist. | Centers for Medicare & Medicaid Services

Organizational Change Manager - Information Technology | Public Consulting Group |

SourceURL: https://www.linkedin.com/jobs/view/1178906241/

Overview

Public Consulting Group, Inc. (PCG) is a leading public sector management consulting and operations improvement firm that partners with health, education, and human services agencies to improve lives. Founded in 1986 and headquartered in Boston, Massachusetts, PCG has over

2,000 professionals in more than 50 offices around the US, in Canada and in Europe. PCG's Technology Consulting practice offers a full spectrum of quality Information Technology (IT) services to help state and local government agencies at every stage of the IT life cycle. Through its specialized IT services, PCG's Technology Consulting team finds cost-effective ways to help agency partners deliver successful IT systems that enhance the lives of the user base.

Responsibilities

- Responsible for organizational migration, gap analysis, and coordination of program improvement, communications, and training activities related to MEMS Modules, MMIS Core Solutions, Medicaid DSS/DW and SI.
- Responsible for OCM Plan.

Qualifications

- BA/BS-Bachelor's degree or equivalent experience required.
- Three (3) years of previous OCM experience preferred.
- Medicaid experience a plus.

UAS Nurse - Bronx | Fidelis Care |

SourceURL: https://www.linkedin.com/jobs/view/uas-nurse-bronx-at-fidelis-care-1174875715/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

HourlyPosition Purpose Responsible for members gaining access to needed services through coordination and integration of medical and long term care services for the purpose of orientation, care plan development, assessment, and care coordination.

Complete assessments with members, caregivers, or providers to obtain information regarding client status, support system, and need for services for care plan development
Monitor delivery of services and follow-up with members, caregivers, or providers through in person visits and telephonic contact
Authorize and coordinate referral for services
Ensure provider services are delivered without gaps and identify functional deficiencies in plans of care
Assist in coordinating the development of informal or voluntary services to integrate into the member care plan
Collaborate with discharge planners, physicians, and other parties to ensure appropriate discharge plan, care plan, and coordination of acute care and long term care services
Assist member with filing and resolving complaints and appeals
Direct care to participating network providers
Participate in care management committees and work on special projects related to care management as needed
Education/Experience 3+ years of care management experience preferred, Home health, discharge planning, or long term care experience preferred.

Licenses/Certifications Valid driver's license. NYS RN license required.

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.

Industry

- Hospital & Health Care
- Insurance

Employment Type

Full-time

Job Functions

- Health Care Provider

Operations Analyst, Associate Operations Excellence | UPMC Health Plan |

SourceURL: https://www.linkedin.com/jobs/view/operations-analyst-associate-operations-excellence-at-upmc-health-plan-1175361954/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Description

Are you a health insurance professional with claims processing experience? If so, an opportunity as an Operations Analyst, Associate with UPMC Health Plan's Operations Excellence team may be the perfect fit for you. This role oversees administrative, system processes and special projects as they relate to the identification, implementation and maintenance of the claims transactional system for all UPMC Health Plan products. Under the general direction of Business Support Management, this role will analyze, identify, propose and implement solutions for all business areas. Additionally, this role acts as subject matter expert supporting all areas, and interact with staff to answer questions and resolve issues as they arise.

Responsibilities

- Assists other departments during periods of backlogs
- Completes Executive Summary management documentation as required
- Completes inquiries generated from the data reporting and analysis area
- Effectively prioritize and complete all assigned tasks
- Identify areas of concern that may compromise client satisfaction through data analysis, and propose solutions based on findings, expertise, and research
- Identify, administer, test, audit, and implement new processes on transactional claims systems
- Interface with customers by telephone, correspondence, and or in person to answer inquiries and resolve concerns/issues
- Maintains employee/insured confidentiality
- Manages, updates, and maintains source data dictionaries as they relate to processes
- Model business requirements for new systems, special projects and enhancements to existing systems; validate and test fixes/enhancements to new and existing systems
- Openly participate in team meetings, provide ideas and suggestions to ensure client satisfaction, and promote teamwork
- Participates in training programs when available/as requested
- Performs in accordance with system-wide competencies/behaviors

- Performs other duties as assigned

Qualifications

- Bachelor's Degree or equivalent work experience.
- Minimum two years general business experience.
- Experience in health care insurance or health care industry preferred, but those with relevant experience in other industries will be considered.
- Knowledge of Commercial, Medicaid, Medicare and Individual products preferred.
- Competence in Microsoft Office required, including Excel, Access, Word
- Excellent planning communication, documentation, analytical and problem solving abilities.
- Ability to work in a fast-paced environment.
- Must possess strong interpersonal, organizational, and project management skills, with the ability to work on multiple tasks simultaneously.
- Previous health insurance claims experience is highly preferred.
- Previous data analyst experience is preferred.
- Previous demonstrated analytical experience is highly preferred

Licensure, Certifications, and Clearances:

Medicaid Billing Specialist | VITAS Healthcare |

SourceURL: https://www.linkedin.com/jobs/view/medicaid-billing-specialist-at-vitas-healthcare-1136394094/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Why VITAS Healthcare and What Do They Offer Me?

VITAS Healthcare is the nation's leading provider of end of life care. We provide our employees opportunities for professional growth, advancement and competitive benefits.

Benefits Include

- Competitive compensation
- Health, dental, vision, life and disability insurance
- Pre-tax healthcare and dependent care flexible spending accounts
- Life insurance
- 401(k) plan with numerous investment options and generous company match
- Cancer and/or critical illness benefit
- Tuition Reimbursement
- Paid Time Off
- Employee Assistance Program
- Legal Insurance
- Roadside Assistance
- Affinity Program

The Caseworker is that member of patient care operations whose primary function is to assist in providing direct casework services to the patient and family within the hospice program of care.

- Provides assistance to the Corporate Patient Accounting Department in collection of claims with regards to their particular programs.

- Evaluates all patients considered for admission as Medicaid pending through completing a financial assessment.
- Takes a proactive role in the application process which includes submitting application, providing periodic updates with agency workers, gathering information and following up with the patient/family regarding their responsibilities and participation throughout this process.
- Actively works with the Admissions Department during the intake process to aid in establishing the correct payor source.

Qualifications

- Qualified candidates will possess a minimum of two (2) years experience in a health-care environment in which the primary job function was community resources utilization which included patient contact.
- Reliable transportation with adequate insurance coverage for driver and passenger or requires ability to cope with the stress of experiencing repeated loss.
- Extensive knowledge of community resources within the specific community in which the hospice is located.
- Knowledge of local, county, applicable state and federal assistance programs.
- Capacity to work with minimal supervision.
- Ability to become proficient in company software programs.

Education

- Bachelor's Degree in Social Work or a related Social Science field from an accredited school preferred, not required.

Special Instructions to Candidates

EOE/AA
M/F/D/V

Health Insurance Marketplace Navigator | Charlotte Center for Legal Advocacy |

SourceURL: https://www.linkedin.com/jobs/view/health-insurance-marketplace-navigator-at-charlotte-center-for-legal-advocacy-1174814013/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Full-time Position Available

Charlotte Center for Legal Advocacy, a non-profit agency that provides legal

assistance in civil matters to low-income persons in Charlotte and Western North Carolina,

seeks a Health Insurance Marketplace Navigator for its Family Support and Health Care

Program. More information about Charlotte Center for Legal Advocacy can be found on its

web page, www.charlottelegaladvocacy.org.

Health Insurance Marketplace Navigator Will

- Conduct education and outreach about Medicaid, CHIP, and Marketplace coverage under the Affordable Care Act and to individuals in Mecklenburg, Union, and Cabarrus Counties.
- Facilitate health insurance enrollment through one-on-one in person meetings with consumers in various community locations.
- Educate consumers about eligibility for health insurance programs and assist with applications for Qualified Health Plans (QHPs), Medicaid, and NC Health Choice (CHIP).
- Help individuals understand premium tax credits and their potential financial impact.
- Facilitate plan selection based on the needs of the individual/family or the small business seeking health insurance coverage.
- Conduct in-reach to existing Charlotte Center for Legal Advocacy clients who may qualify for a health insurance affordability program.
- Work with community partners including other non-profit organizations, medical clinics, health departments, churches, libraries, job-training programs and other stakeholders to coordinate outreach efforts and connect with uninsured individuals/ families.
- Work with other local Navigators and CACs to organize enrollment events.
- Provide referrals to appropriate agencies, including the North Carolina Department of Insurance for applicants and enrollees with grievances, complaints, questions, or need for other social services.
- Provide all information and services in a manner that is culturally and linguistically appropriate and ensure accessibility for individuals with disabilities.
- Work with English and Spanish language media (including print, radio and television) to share information on open enrollment and the availability of in-person assistance.

Qualifications Desired

- Four-year degree in social work, public health, public policy, communications, paralegal studies, or related field, OR equivalent experience.
- Spanish language proficiency preferred.
- Experience working with low-income communities preferably at a non-profit or community-based organization within a multi-ethnic/multi-cultural environment.
- Experience in public benefit eligibility or enrollment and/or work experience as an enrollment service representative.

- Proficiency in MS Office, including Word, Excel, Power Point and Adobe PDF

professional.

- Ability to work independently and in a team environment.
- Ability to effectively collaborate with co-workers and clients face-to-face and in meeting

settings.

General Requirements

- Once hired, must successfully complete and pass the Certification Training to be

provided by Center for Consumer Information and Insurance Options (CCIIO).

- Must be free from conflicts of interests, including payments and incentives from brokers,

insurers or insurance industry.

- Must own a reliable car with car insurance and have a valid driver's license.
- Must be able to work nights and weekends, particularly during open enrollment.
- Must possess socio-economic and cultural sensitivity and the realization and sensitivity

that the Navigator may come in contact with angry, upset, or ill persons.

- Must be able to multi-task with long periods of sitting or standing and interact with

professionals, clients, patients, and other office personnel.

Start Date

Position is open immediately.

Classification

The position is classified as paralegal-advocate on the Charlotte Center for Legal Advocacy salary scales. Full time, annual salary $31,500+ (depending on experience); generous leave and benefits.

To Apply send all of the following: (1) a detailed letter explaining your qualifications for and your interest in this specific position and this organization, a description of your Spanish language proficiency, experience with low-income individuals, special qualifications for this program and other relevant information; (2) a resume; (3) a writing sample; and (4) the names and telephone numbers of three references to: Brittany Chadwick, Charlotte Center for Legal Advocacy, by email to brittanyc@charlottelegaladvocacy.org or by mail to 1431 Elizabeth Avenue, Charlotte, NC, 28204, email is preferred. Form letters and inquiries not containing this information will not be considered.

Charlotte Center for Legal Advocacy is an equal opportunity employer.

Veterans, women, minorities and disabled persons are encouraged to apply.

MISSION. The mission of the Charlotte Center for Legal Advocacy Family Support and Health Care Program is to ensure that low-income children, the elderly, disabled persons, immigrants and their families have access to health care and public services.

CASE TYPES. The major problems or issues addressed by this program are access to:

- VA Disability
- Emergency assistance
- Medicaid and Medicare
- Child care assistance
- Child Health Insurance Program (CHIP)
- Child support enforcement services
- Food Stamps
- Quality nursing and rest home care
- Supplemental Security Income
- Work First Family Assistance
- Social Security
- Benefit diversion
- Mental health services
- Employment supportive services

  GOALS AND OBJECTIVES. This program focuses on the following four issues:
  - Access to quality health care for children and their parents in low and moderateincome

  families through Medicaid, the Children's Health Insurance Program, and private health insurance coverage.
  - Assisting families on welfare, formerly on welfare, or in danger of needing welfare, in

  becoming or remaining self-sufficient, by improving access to child support enforcement, quality child care, higher education, training, transportation, treatment of substance abuse, Food Stamps, the Earned Income Tax Credit and other tax **Benefits, Medicaid, Affordable Housing, And Other Supportive Services.**
  - Improving health care and income support for the disabled and elderly poor, with a

  focus on issues involving Social Security, SSI, Medicaid, Medicare, and on improving mental health services, care in nursing and rest homes, access to community-based care, services to the HIV-positive population, and managed care.
  - Working closely with Charlotte Center for Legal Advocacy's Immigrant Justice Project to address the above issues as they impact the immigrant population in this region, including addressing language barriers and other barriers which particularly limit access of immigrants, non-English speaking citizens, and their children to public services and health care.

  Program representation is designed both to obtain specific relief for the individuals and families who contact the program for assistance, and also to utilize systemic advocacy strategies to change the rules, procedures and practices of federal and state agencies to ensure access to health care and public services for all affected persons. Measured outcomes will show the number of persons assisted and the dollar value of benefits or services obtained.

CHC Service Coordinator RN | UPMC Health Plan |

SourceURL: https://www.linkedin.com/jobs/view/chc-service-coordinator-rn-at-upmc-health-plan-1175363092/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

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
- Collects 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, and 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

- Registered Nurse
- At least three years working in social service or health care related setting
- 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

Registered Nurse

Manager, Care Coordination (Medicaid) Denver, CO

SourceURL: http://ejob.bz/ATS/PortalViewRequirement.do?reqGK=27169336&utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Description

Position Summary: Responsible for cross-program operations of CCHA Care Coordination programs. Collaborates across departments, including behavioral health, to create integrated priorities, and implement strategies and initiatives to achieve CCHA goals and outcomes. Supports alignment of CCHA's care coordination programs though focusing on operational efficiencies and program evaluation. Provides clinical management support to the CCHA Care Coordination management and supervisor team, including integration of physical & behavioral health. Works with the Care Coordination Director and leadership team to coordinate content and completion of CCHA Care Coordination deliverables. Represents CCHA's Care Coordination programs in community, stakeholder and HCPF meetings.

COMPETENCIES/Role-Specific Functions:

ORGANIZATIONAL SAVVY

Operates within the organization's formal and informal structures, builds allies and relationships across departments, uses allies to build consensus and create results, is appropriately diplomatic, understands others' roles and perspectives, can sell projects and ideas across the organization.

- Coordinates with Director and managers to provide leadership and direction on cross-program design, implementation and evaluation.
- Works with the Care Coordination Director to initiate, plan and represent CCHA in community, provider and HCPF activities.
- Coordinates across CCHA departments to assist with operationalizing CCHA's care coordination programs within the health neighborhood, provider offices, hospitals, and the community.
- Works with Director to support analysis and program data to include making suggestions for and implementing clinical process changes, improvements, program design and implementation of new initiatives.
- Creates and maintains successful relationships within the broader RAE structure, including other CCHA departments, BH leadership, community stakeholders and providers.

DECISION MAKING/JUDGEMENT

Recognizes problems and responds, systematically gathers information, sorts through complex issues, seeks input from others, addresses root cause of issues, makes timely decisions, can make difficult decisions, uses consensus when possible, communicates decisions to others.

- Assists direct reports in decision making to monitor effectiveness of care coordination initiatives and programs.
- Collaborates in decision making and problem solving when appropriate with directors and managers.

PLANNING

Develops realistic plans, sets goals, aligns plans with company goals, plans for and manages resources, creates contingency plans, coordinates/cooperates with others.

- Supports cross-program processes for identification and assignment of targeted populations to maximize effectiveness of care coordination programs; and data analysis to ensure adherence and fidelity to the programs and workload leveling.
- Works with leadership to implement & evolve programs throughout the evolution of the RAE, HCPF and market changes.
- Works with the Care Coordination Director and leadership team to coordinate content and completion of CCHA Care Coordination deliverables.

PEOPLE MANAGEMENT

Defines roles and responsibilities, applies clear/consistent performance standards and provides feedback and coaching. Handles performance problems decisively and objectively, provides guidance and assistance to improve performance, rewards hard work and risk taking, motivates, challenges and develops employees, delegates effectively.

- Performs coaching, mentoring, oversight and development for CCHA's Care Coordination management team.
- Works with the Director and other managers to develop policies and procedures, productivity reports and compliance monitoring.

CUSTOMER FOCUS

Plans for and uses resources efficiently, always looks for ways to reduce costs, creates accurate and realistic budgets, tracks and adjusts budgets, contributes to budget planning.

- Develops and maintains a good working relationship with CCHA key partnerships
- Ensures reporting commitments to key partners, including HCPF and providers, are met

JOB KNOWLEDGE

Understands duties and responsibilities, has necessary job knowledge, has necessary technical skills, understands company mission/values, keeps job knowledge current, is in command of critical issues.

- Provides clinical oversight of all outpatient Care Coordination functions including, but not limited to, CCHA Care Coordination cross-program design and implementation, care transitions and care coordination processes.
- Represents CCHA Care Coordination in internal meetings and workgroups and community based organizations.

BUDGETING

Plans for and uses resources efficiently, always looks for ways to reduce costs, creates accurate and realistic budgets, tracks and adjusts budgets, contributes to budget planning.

- Other duties as assigned.

Qualifications (Education/Experience/Knowledge/Skills):

- Graduate of accredited school of nursing with RN, Licensed Clinical Social Worker, or Masters level health care related degree. Minimum 5 years clinical experience as

RN or Licensed Clinical Social Worker, or Masters level health care related degree.
- Minimum 5 years experience in management of healthcare related staff
- Minimum 3 years experience in program design, implementation, and evaluation
- Experience with Health First Colorado, Colorado's Medicaid program preferred
- Knowledge of NCQA, QA, Medicare/Medicaid guidelines, program and workflow development, process improvement and implementation procedures, care coordination, especially care transitions models and health coaching models
- Skilled in exercising a high degree of initiative to achieve organizational objectives
- Skilled in teaching others and acting as a subject matter expert, motivational interviewing, judgment and decision-making, customer service by being able to relate well to all kinds of people inside and outside the organization, builds appropriate rapport, uses diplomacy and tact, can diffuse even high-tension situations comfortably
- Able to perform intermediate level of competence with various computer software applications including MS Outlook, Word, Excel, Access, and Power Point
- Able to think critically and problem solve varying degrees of complexity
- Able to earn respect of practices and peers and community organizations
- A valid unrestricted Colorado drivers' license.
- Reliable and insured vehicle.

Medicaid Eligibility Specialist | VillageCare |

SourceURL: https://www.linkedin.com/jobs/view/medicaid-eligibility-specialist-at-villagecare-1176473849/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Roles & Responsibilities

The Medicare Eligibility Specialist confirms pre-enrollment Medicaid and eligibility of applicants, supports enrollment processing, and disenrollment processing of all VillageCareMAX Medicaid products.

- Maintains and reconcile VillageCareMAX membership systems to reflect most current enrollment and disenrollment information for designated Medicaid products in eCARE, eClaims, and M360
- Outreach to external vendors to resolve or correct systems issues, eligibility issues, and various discrepancies pertaining to enrollment and disenrollment functions
- Audits and reviews all Medicaid applications prior to submission for Medicaid
- Confirm timely processing of all Medicaid enrollment and disenrollment letters
- Reconcile daily and month files from state and CMS to confirm enrollment and disenrollment eligibility and reports changes to VillageCareMAX staff
- Act as a liaison between plan and state to follow up on the timely and accurate processing of enrollments/disenrollments and escalated enrollment/disenrollment issues
- Create and maintain monthly enrollment and disenrollment reports for enrollment team, VillageCareMAX operations department, and various VillageCareMAX departments for Medicaid (Report types include: enrollment tracking, disenrollment tracking, cancellation, and monthly census)
- Assist in the monthly reconciliation of MMR report to confirm eligibility and billing
- Assist in the training of new staff in MLTC and Medicaid care enrollment and disenrollment guidelines
- Be appointed back up for MLTC Enrollment Specialist

- Supports Enrollment Operations Manager in special projects or tasks based on departmental needs and goals

Qualifications

- Education: Bachelor's Degree.
- Experience: A minimum of 5-7 years of healthcare experience.

Integrity

You Are a Team Member Who Serves As a Positive Example And Reflection Of Why Others Trust The Intentions Of VillageCare By

- Being honest and trustworthy
- Meeting your commitments and obligations
- Acknowledging your role in actions or events with unsatisfactory outcomes

Customer Focus/Cultural Awareness

You Are Consistently Customer Focused By

You are a team member who understands the importance of strong customer service internally and externally and you demonstrate this by identifying customer needs and expectations, and responding to them in a timely and effective manner.

- Demonstrating an awareness of the needs of individuals through recognizing multiple levels of connections
- Anticipates and prevents delays or other things that can adversely affect the customer.
- Keeping customers informed about the status of pending actions and inquires

Flexibility/Agility

As Such, You Are Flexible And Agile By

You are a team member who adjusts quickly and effectively to changing conditions and demands. You understand that change is a necessary and an inevitable aspect of organizational life as well as an opportunity to learn new things.

- Maintaining a positive view of potentially stressful situations
- Accepting and adapting to organizational or departmental changes
- Viewing change as opportunities for VillageCare to grow in a direction that better serves our clients and our employees

Result Oriented/Innovative Thinking

You Champion New Ideas And Build Upon Existing Processes By

You are a team member who consistently looks for new and innovative approaches that will improve efficiency in your role.

- Using data/fact-based information to make decisions relevant your role
- Understands that obstacles will occur and refuses to use them as an excuse for not achieving results

BEVital

You Are a Team Member That Consistently Supports VillageCare's Larger Organizational Culture By Displaying a Commitment To The Three Cultural Drivers That Make VillageCare And Our Employees Vital To The Healthcare Space By

- Exceeding expectations in both internal and external customer service areas
- Using data and key information to inform decisions pertinent to your role (where applicable)
- Utilizing relationships, tools and positivity to enhance organizational performance through communication and collaborative team work

VillageCare is committed to superior outcomes in quality health care. Do you share a common commitment to patient care, customer service and passion for individuals' well-being?
Apply now!

VillageCare

With over 25,000 people served in 2017, VillageCare's mission is to promote healing, better health and well-being to the fullest extent possible.
VillageCare began in 1977 as a project by community volunteers to rescue and reorganize a for-profit nursing home slated for closure. It has become a much larger organization that provides post-acute care, community-based services and managed long-term care. As a result of this history, VillageCare has become a valued resource for the people we serve, their caregivers and other provider organizations with which we partner.
VillageCare is committed to the tenets of diversity and workforce that are strengthened by the inclusion of and respect for our differences. We offer our employees a highly competitive compensation and benefits package, a 403(b) retirement plan, and much more.
VillageCare is an equal opportunity employer. We promote recognition and respect for individual and cultural differences, and we work to make our employees feel valued and appreciated, whatever their race, gender, background, or sexual orientation.
EOE Minorities/Women/Disabled/Veterans

WAVIER MANAGER | Arizona Health Care Cost Containment System (AHCCCS) |

SourceURL: https://www.linkedin.com/jobs/view/wavier-manager-at-arizona-health-care-cost-containment-system-ahcccs-1168270118/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

First Resume Review: 3/22/19

Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid Agency, is driven by the passion to deliver comprehensive and cost effective health care to Arizonans in need. AHCCCS is nationally acclaimed as a model for other Medicaid programs and recipient of multiple awards for excellence in workplace effectiveness and flexibility.

All Arizona state employees operate within the Arizona Management System (AMS), an intentional, results-driven approach for doing the work of state government whereby every employee reflects on performance, reduces waste, and commits to continuous improvement with sustainable progress. Through AMS, every state employee seeks to understand customer needs, identify problems, improve processes, and measure results. State employees are highly engaged, collaborative and embrace a culture of public service. Visit our **careers page** to learn more about AHCCCS. Use your skills to benefit others; join the AHCCCS Team!

Job Summary

The newly established **Division of Health Care Advocacy & Advancement (DHCAA)** ensures Health Plan and Program Contractors' resolution of consumer affairs and human rights issues and compliance with related aspects of their contracts. The DHCAA is looking for a highly motivated individual to join our team as a Wavier Manager . This position serves a key role in managing Arizona's Section 1115 Research and Demonstration Waiver, serve as the point person for 1115 waiver evaluations, performing health policy research and sophisticated policy analysis, giving public presentations, and working closely with AHCCCS staff, CMS (Centers for Medicare & Medicaid Services) staff, and other officials and stakeholders. Major duties and responsibilities include but are not limited to:

- Serve as the point person for 1115 Wavier evaluation including building, maintaining, and managing the evaluation structure for each of the unique demonstrations within the 1115 Waiver. Ensure goals and objectives within the Waiver are connected to broader initiatives with the agency. Coordinate activities with the various independent third party evaluators.
- Manage Arizona 1115 Waiver including, but not limited to researching and drafting 1115 Waiver proposals ensuring AHCCCS meets federal public notice and other requirements. Plan, organize and present at public forums regrading proposed 1115 Waiver changes; and timely submission of federal reporting and 1115 Waiver deliverables to CMS.
- Provide updates on evaluation milestones to CMS and Executive Management. Prepare administrative reports for CMS and the public on evaluation results and successes of demonstrations.
- Work with the Health Policy & Strategic Planning Consultant to manage and update Medicaid and CHIP (Children's Health Insurance Program) State Plans as needed.
- Conduct research and analysis on health care policy including federal and state legislation and draft issue papers containing in-depth analysis and recommendations. Monitor the evolution of other states' Medicaid programs as well as policy developments/trends at the national level and summarize for executive management.
- Coordinate policy research/analysis teams and providing a framework for discussion of complex policy issues. Review CMS guidance, proposed and final rules and work with internal subject matter experts to draft and submit AHCCCS comments.

KNOWLEDGE, SKILLS AND ABILITIES (KSAs)

- Arizona's Medicaid and CHIP program, federal and state laws and regulations related to Medicaid including 1115 Waivers and State Plan and other federal and state health programs.
- The principles, methods, or tools for developing, scheduling, coordinating, and managing projects and resources, including monitoring and inspecting costs and work, risk management and mitigation of risk.
- Excellent research and analytical skills, ability to conceptualize new health policy proposals and develop recommendations, and ability to propose solutions to complex policy issues.
- Interpersonal skills, developing and maintaining professional working relationships as applied to staff, representatives of other governmental agencies and the public.
- Excellent verbal and written communications skills
- Work and project manage multiple external independent vendors who conduct evaluation of different demonstrations with Wavier and develop a work plan and anticipate all work steps including potential issues.
- Adapt to a rapidly changing environment and priorities, effectively deal with ambiguity

Selective Preference(s)

- Three (3) years' experience related to health care policy
- An advanced degree from an accredited college or university in policy, or health-related discipline.
- Demonstrated work experience in developing, conducting evaluations in a health care related field.

Benefits

At AHCCCS, we promote the importance of work/life balance by offering workplace flexibility and a variety of learning and career development opportunities. Among the many benefits of a career with the State of Arizona, there are 10 paid holidays per year, accrual of sick and annual leave, affordable medical benefits and participation in the Arizona State Retirement Plan. **Click here** to learn more about benefits.

Arizona State Government is an EOE/ADA Reasonable Accommodation Employer. Persons with a disability may request a reasonable accommodation such as a sign language interpreter or an alternative format by calling (602) 417-4497. Requests should be made as early as possible to allow sufficient time to arrange the accommodation. AHCCCS is an Equal Employment Opportunity Employer. All newly hired employees will be subject to E-Verify Employment Eligibility Verification.

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

SourceURL: https://www.linkedin.com/jobs/view/health-insurance-specialist-at-centers-for-medicare-medicaid-services-1175034563/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

- Duties
  Summary

  This position is located in the Department of Health & Human Services (HHS), Centers for Medicare & Medicaid Services (CMS), Center for Medicaid and CHIP Services, State Demonstrations Group (SDG) .

  As a Health Insurance Specialist, GS-0107-12, you will perform program policy work related to national health insurance programs, such as Medicare, Medicaid, the Children's Health Insurance Program (CHIP), Marketplace Exchange/private health insurance.

  Responsibilities
  - Develop, evaluate, refine and review regulations, rulings, manuals, program guidelines, program memoranda, policy letters, and/or instructions to effectively communicate and disseminate program policies related to CMS? lines of business.
  - Provide technical assistance to stakeholders (e.g., Medicare, Medicaid, and/or private insurance that provide health care and drug services, and Providers), on CMS requirements.
  - Coordinate and prepare responses to Office of the Inspector General (OIG) and Government Accountability Office (GAO) actions, and monitor progress of associated corrective action plans.
  - Work with managers and subject matter experts in order to provide timely responses to the appropriate CMS component lead.
  - Develop, implement, and maintain operational requirements, including standard operating procedures, as well as databases, to manage and analyze programmatic information such as routine and ad hoc report, deliverables, and programmatic documentation.
- Travel Required

- Occasional travel - You may be expected to travel for this position.
- Supervisory status
- No
- Promotion Potential
  12
- Job family (Series)
- Requirements

  Conditions of Employment
    - You must be a U.S. Citizen or National to apply for this position.
    - You will be subject to a background and suitability investigation.
- **Qualifications**
-
- **ALL QUALIFICATION REQUIREMENTS MUST BE MET BY THE CLOSING DATE OF THIS ANNOUNCEMENT.**
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- **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:A. I have 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 national health insurance program policy issues in order to make policy recommendations; (2) Refining regulations, manuals, program guidelines, program memoranda, policy letters, and/or instructions to communicate health insurance program policies; and (3) Presenting findings or recommendations based on analysis of health insurance programs.
- 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.
- Education
- Additional information
- **Bargaining Unit Position:** Yes
- **Tour of Duty:** Flexible
- **Recruitment/Relocation Incentive:** Not authorized
- **Financial Disclosure:** Not required
- CMS employees currently participating in 100% Full-Time Telework Program may be eligible to remain in the program. If an employee in this program is selected, the pay will be set in accordance with the locality pay for the applicable duty station. The listed salary range reflects the locality pay assigned to the duty location(s) listed in the vacancy announcement. For more information about pay based on locality, please visit the
- **The Interagency Career Transition Assistance Plan (ICTAP) and Career Transition Assistance Plan (CTAP)** provide eligible displaced federal employees with selection priority over other candidates for competitive service vacancies. To be qualified you must submit the required documentation and be rated well-qualified for this vacancy.
- **Additional Forms REQUIRED Prior To Appointment**
    - **Optional Form 306, Declaration of Federal Employment and the Background/Suitability Investigation** - A background and suitability investigation will be required for all selectees. Appointment will be subject to the successful completion of the investigation and favorable adjudication. Failure to successfully meet these requirements may be grounds for appropriate personnel action. In addition, if hired, a reinvestigation or supplemental investigation may be

required at a later time. If selected, the Optional Form 306 will be required prior to final job offer. Click here to obtain a copy of the Optional Form 306.
    - **Form I-9, Employment Verification and the Electronic Eligibility Verification Program** - CMS participates in the Electronic Employment Eligibility Verification Program (E-Verify). E-Verify helps employers determine employment eligibility of new hires and the validity of their Social Security numbers. If selected, the Form I-9 will be required at the time of in-processing. Click here for more information about E-Verify and to obtain a copy of the Form I-9.
    - **Standard Form 61, Appointment Affidavits** - If selected, the Standard Form 61 will be required at the time of in-processing. Click here to obtain a copy of the Standard Form 61
- Additional selections may be made from this announcement for similar positions within CMS in the same geographical location. For Central Office vacancies, the "same geographical location" includes Baltimore, Maryland; Bethesda, Maryland; and Washington, D.C.
- If you are unable to apply online or need to fax a document you do not have in electronic form, view the following link for information regarding an
- 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 them
- 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:
- **CMS Required Documents (e.g., SF-50, DD-214, SF-15, etc.).** Required documents may be necessary to be considered for this vacancy announcement.
- **College Transcripts.** Although this position does not require a degree, you may substitute college credit in whole, or in part, for experience at specified grade levels. You must submit a copy of your transcript at the time of application in order to substitute your education for the required experience. If you do not submit a transcript, your education will not be considered in determining your qualifications for the position. You may submit an unofficial transcript or a list of college courses completed indicating course title, credit hours, and grades received. An official transcript is required if you are selected for the position.
  College Transcripts and Foreign Education: Applicants who have completed part or all of their education outside of the U.S. must have their foreign education evaluated by an accredited organization to ensure that the foreign education is comparable to education received in accredited educational institutions in the U.S. For a listing of services that can perform this evaluation, visit the
  PLEASE NOTE: A complete application package includes the online application, resume, transcripts (if qualifying through education substitution or a combination of education and experience) and CMS required documents. Please carefully review the full job announcement to include the "Required Documents" and "How to Apply" sections. Failure to submit the online application, resume, transcripts (if applicable) and CMS required documents, will result in you not being considered for employment.
  If you are relying on your education to meet qualification requirements:

Education must be accredited by an accrediting institution recognized by the U.S. Department of Education in order for it to be credited towards qualifications. Therefore, provide only the attendance and/or degrees from
Failure to provide all of the required information as stated in this vacancy announcement may result in an ineligible rating or may affect the overall rating.

- Benefits

  A career with the U.S. Government provides employees with a comprehensive benefits package. As a federal employee, you and your family will have access to a range of benefits that are designed to make your federal career very rewarding.

  Eligibility for benefits depends on the type of position you hold and whether your position is full-time, part-time, or intermittent. Contact the hiring agency for more information on the specific benefits offered.
- How to Apply

  Your complete application package, as described in the "Required Documents" section, must be received by 11:59 PM ET on 03/18/2019 to receive consideration.

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

  Please Ensure EACH Work History Includes ALL Of The Following Information

  We strongly encourage applicants to utilize the USAJOBS resume builder in the creation of resumes.
    - Official Position Title (include series and grade if Federal job)
    - Duties (be specific in describing your duties)
    - Employer's name and address
    - Supervisor name and phone number
    - Start and end dates including month, day and year (e.g. June 18, 2007 to April 05, 2008)
    - Full-time or part-time status (include hours worked per week)
    - Salary
- **Determining length of general or specialized experience is dependent on the above information and failure to provide ALL of this information WILL result in a finding of ineligible.**
    - To begin, click **Apply** to access the online application. You will need to be logged into your USAJOBS account to apply. If you do not have a USAJOBS account, you will need to create one before beginning the application.
    - Follow the prompts to **select your resume and/or other supporting documents** to be included with your application package. You will have the opportunity to upload additional documents to include in your application before it is submitted. Your uploaded documents may take several hours to clear the virus scan process.
    - After acknowledging you have reviewed your application package, complete the Include Personal Information section as you deem appropriate and **click to continue with the application process**.
    - You will be taken to the online application which you must complete in order to apply for the position. Complete the online application, verify the required documentation is included with your application package, and submit the application.
- To verify the status of your application, log into your USAJOBS account (
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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 Lawanda.carter@cms.hhs.gov. The decision to grant reasonable accommodation will be made on a case-by-case basis.
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- **Commissioned Corps Officers** (including Commissioned Corps applicants that are professionally boarded) who are interested in applying for this position must send their professional resume (not PHS Curriculum Vitae) and cover letter to

Agency contact information

LaWanda Carter

Address

Center for Medicaid and CHIP Services
7500 Security Blvd
Woodlawn, MD 21244
US

Next steps

- Once your online application is submitted, you will receive a confirmation notification by email. Within 30 business days of the closing date,03/18/2019, you may check your status online by logging into your USAJOBS account (
- Fair & Transparent

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

  Equal Employment Opportunity Policy

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

  Reasonable Accommodation Policy

  Federal agencies must provide reasonable accommodation to applicants with disabilities where appropriate. Applicants requiring reasonable accommodation for any part of the application process should follow the instructions in the job opportunity announcement. For any part of the remaining hiring process, applicants should contact the hiring agency directly. Determinations on requests for reasonable accommodation will be made on a case-by-case basis.

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

  Under the Rehabilitation Act of 1973, federal agencies must provide reasonable accommodations when:
    - An applicant with a disability needs an accommodation to have an equal opportunity to apply for a job.
    - An employee with a disability needs an accommodation to perform the essential job duties or to gain access to the workplace.
    - An employee with a disability needs an accommodation to receive equal access to benefits, such as details, training, and office-sponsored events.

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