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Medicaid Jobs Hunter

1. Compliance Specialist Job in Detroit, MI at Meridian Health Plan
2. State of Minnesota hiring Human Services Program Consultant - Mental Health Medicaid Benefits Specialist in St Paul, MN
3. Fallon Health hiring RN Clinical Manager - Growing Elder Service Program - Lowell MA - Fallon Community Health Plan in Lowell, MA
4. Director Finance (Medicaid) Insurance - Southfield, MI at Geebo
5. Centene Corporation hiring Transition Nurse RN in San Bernardino, CA
6. The Children's Village hiring Medicaid Behavioral Health Services Manager in Dobbs Ferry, NY
7. State of Louisiana hiring MEDICAID PROGRAM MANAGER 4 (Medicaid EPO Section Chief) in Baton Rouge, LA
8. Presbyterian Healthcare Services hiring CLAIMS QUALITY SPEC - MEDICAID CLAIMS in Albuquerque, NM
9. Centers for Medicare & Medicaid Services hiring Pharmacist in Gwynn Oak, MD
10. Steward Health Care System hiring Senior Analyst, Medicaid ACO in Needham, MA

Compliance Specialist Job in Detroit, MI at Meridian Health Plan

SourceURL: https://www.ziprecruiter.com/c/Meridian-Health-Plan/Job/Compliance-Specialist/-in-Detroit,MI?ojob=685e50a78de5fb29291d50ccac823142

Overview

Meridian, a WellCare Company, is part of a national network of passionate leaders, achievers, and innovators dedicated to making a difference in the lives of our members, our providers and in the healthcare industry.

We provide government-based health plans (Medicare, Medicaid, and the Health Insurance Marketplace) in Michigan, Illinois, Indiana, and Ohio. As a part of the WellCare Family of companies, we deliver healthcare excellence to millions of members nationwide.

Our associates work hard, play hard, and give back. Meridian associates enjoy an exceptional experience and culture including special events, company sports teams, potlucks, Bagel Fridays, and volunteer opportunities.

Responsibilities

Essential Functions:
+ This position records, aggregates, analyzes, and reports audit results, identifying error trends and root causes, and making recommendations for performance improvements
+ Conduct standard random audits and focused audits to determine compliance to departmental standards
+ Participate in the research of federal, state, and contractual requirements to assist in the development of routine compliance monitorings
+ Assist in CMS HPMS memo dissemination
+ Participate in the development, implementation and ongoing compliance monitoring of all vendors, contractors and subcontractors to ensure all requirements and responsibilities are addressed
+ Initiates, facilitates, and promotes activities to foster compliance awareness and to encourage reporting of compliance issues within the organization and related entities
+ Provide oversight and monitoring to the policies and procedures library and work with department liaisons to ensure policies are up to date.
+ Conduct periodic audits for performance management and proper coding. Identify and track top error trends and conduct root cause analysis based on audit results. Identify and recommend process improvement initiatives based on audit trends and root cause analysis. Maintain accurate database of audit results
+ Develop new, and review existing, Medicare & Medicaid policies & procedures
+ Participate in the review of departmental productivity and performance reports and takes an active part in the development of action plans for performance improvement
+ Remain updated on all member and provider policy changes made by the health plan, CMS and/or the State
+ Work with all departments to ensure member satisfaction and timely resolution of grievances and appeals as requested by leadership.
Perform other duties as assigned

Qualifications

Job Requirements:
Education:
+ Bachelor's degree or Fellow Designation from the Academy of Healthcare Management (AHM) is required

Experience:
+ Customer service experience or related health care industry experience is preferred
+ Experience with MHP's managed care system (MCS), Merlin and Atlas is preferred
+ Experience with Compliance 360 is preferred
+ Demonstrated adaptability and flexibility to changes and response to new ideas and approaches is preferred

Knowledge:

+ Knowledge of managed care and the Medicaid program is preferred
+ Knowledge of Medicare is preferred
+ Knowledge of the health plan programs, benefits, and services for all lines of business for our members
+ Knowledge of National Committee for Quality Assurance (NCQA), URAC or general accreditation standards
+ Knowledge of appeal and grievance guidelines is preferred

Skills:
+ Superior verbal and written communication skills
+ Superior analytical and problem solving skills
+ Excellent computer skills
+ Willingness to work in a team environment with a great sense of customer focus

Abilities:
+ Ability to be patient, courteous and polite to all members, providers and internal customers in all situations
+ Ability to learn new skills and acquire knowledge
+ Ability to think independently and solve problems

Job ID2019-7862
CategoryLegal/Compliance
Business LineCMC Corporate

State of Minnesota hiring Human Services Program Consultant - Mental Health Medicaid Benefits Specialist in St Paul, MN

SourceURL: https://www.linkedin.com/jobs/view/human-services-program-consultant-mental-health-medicaid-benefits-specialist-at-state-of-minnesota-1221277027

Apply on company website

Job description

Job Details

Job Class: Human Svcs Prog Consultant

Working Title: Mental Health Medicaid Benefit Specialist

Job ID: 31859

Location: St. Paul

Full/Part Time: Full-Time

Regular/Temporary: Unlimited

Who May Apply: Open to all qualified job seekers

Date Posted: 04/12/2019

Closing Date: 04/19/2019

Hiring Agency/Seniority Unit: Human Services Dept / DHS Central Office

Division/Unit: DHS-Payroll / MHCP

Work Shift/Work Hours: Day Shift

Days of Work: M-F

Travel Required: No

Salary Range: $27.98 – $41.50/hourly; $58,422 - $86,652/ annually

Classified Status: Classified

Bargaining Unit/Union: 214 - MAPE

FLSA Status: Exempt - Administrative

Job Summary

Job Summary

The position involves statewide travel as necessary to provide technical assistance and policy consultant expertise to counties, providers, and others.

The Mental Health Division is responsible for the development of new Medicaid (Medical Assistance) mental health services, as well as maintaining the quality of, access to and outcomes of existing Medicaid services for Minnesotans with mental illnesses. This position is responsible for managing cross-division staff activities and coordinating the administration of the Community Supports Administration's development, implementation and communication of mental health services coverage policy for all Minnesota Health Care Programs (MHCP) Medicaid services statewide. The position will lead Medicaid, Medicare, and Minnesota Health Care Programs mental health policy for adults as well as supportive responsibilities for Medicaid and Minnesota Health Care Programs mental health policy for children.

The position provides content expertise on state and federal Medicaid rules and regulations to inform Minnesota Health Care Programs policy. The position provides this content expertise to mental health supervisors, mental health directors and deputies, and mental health policy staff for policy analysis, development, and implementation. In the role of liaison to the Managed Care Contract and Compliance unit, this position's responsibilities include communication of changes to existing and new community-based Minnesota health Care Program (MHCP) benefits to contract management staff to ensure consistency of mental health services throughout Prepaid Managed Care Plans (PMAP). In collaboration with staff across the mental health and substance abuse division, this position will provide policy updates through regular communication with behavioral health representatives from contracted health plans and county based purchasing organizations.

To address the need for integrated care models for persons with mental illnesses, co-occurring substance use disorders and co-morbid medical issues, this position will support CSA's initiatives on integrated behavioral health/primary care models and chronic disease models by: 1) establishing program goals and objectives, 2) leading activities of policy experts, agency leadership, and other staff at all levels as they relate to the development of new health care

services and payment models for the behavioral health continuum of care. The incumbent analyzes gaps in the state's mental health service delivery continuum, specific to the physical health and other complex needs of persons with mental illnesses and co-occurring substance use disorders, develops and oversees implementation of community-based service capacity to reduce health risks commonly associated with mental illness.

- Investigate reported and potential problems related to systems issues that impact Minnesota Health Care Programs service implementation, reimbursement policies and outcomes reporting. Operationalize activities between the DHS Health Care Administration and the Mental Health Division related to the development, implementation, monitoring and communication of mental health benefit services in prepaid Minnesota Health Care Programs (PMAP). Facilitate activities in support of mental health service policy implementation through provider training and technical assistance.

The person must be sensitive to and respectful of cultural and other differences that will be encountered while interacting with co-workers and in serving our customers.

Qualifications

Minimum Qualifications:

Bachelor degree or Master's Degree in Health Care Administration, Mental Health, Addiction Studies, Drug & Alcohol Counseling or related field.

Three years of advanced professional experience in the mental health field which demonstrates knowledge of current best practices for mental health treatment services and knowledge of social service system and community supports.

- Ability to utilize state-of-the-art training equipment, such as PowerPoint presentations, document camera, and interactive tele-video conferencing
- Analytical skill sufficient to develop evaluation models to monitor performance of new service models

Preferred Qualifications

- At least five years of experience in Medicaid mental health coverage policy preferred
- Strong technical/leadership/communication skills in order to "hit the ground running" within six months

Additional Requirements

This position requires successful completion of the following:

To facilitate proper crediting, please ensure that your resume clearly describes your experience in the areas listed and indicates the beginning and ending month and year for each job held.

REFERENCE/BACKGROUND CHECKS - The Department of Human Services will conduct reference checks to verify job-related credentials and criminal background check prior to appointment.

Application Details

Why Work For Us

GREAT BENEFITS PACKAGE! The State of Minnesota offers a comprehensive benefits package including low cost medical and dental insurance, employer paid life insurance, short and long term disability, pre-tax flexible spending accounts, retirement plan, tax-deferred compensation, generous vacation and sick leave, and 11 paid holidays each year.

This position is located in Minnesota's great capital city, St. Paul. The State of Minnesota offers employees subsidies for public transportation allowing for convenient and easy access to commute to work. Ride the new METRO "Green Line" Light Rail Train to work! The 10th Street Station is located close by.

Our mission as an employer is to actively recruit, welcome and support a workforce, which is diverse and inclusive of people who are underrepresented in the development of state policies, programs and practices, so that we can support the success and growth of all people who call Minnesota home.

How to Apply

Click "Apply" at the bottom of the page. If you have questions about applying for jobs, contact the job information line at 651-259-3637.

For additional information about the application process, go to http://www.mn.gov/careers.

Contact

If you have questions about the position, contact Deidre Jackson at deidre.s.jackson@state.mn.us

If you are a Connect 700 applicant, please email your certificate and the Job posting ID to Zong Vang at zong.vang@state.mn.us by the position close date.

If you are an individual with a disability and need an ADA accommodation for an interview, you may contact the Department of Human Services' ADA Coordinator at 651-431-4945 for assistance.

AN EQUAL OPPORTUNITY EMPLOYER

The State of Minnesota is an equal opportunity, affirmative action, and veteran-friendly employer. We are committed to providing culturally responsive services to all Minnesotans. The State of Minnesota recognizes that a diverse workforce is essential and strongly encourages qualified women, minorities, individuals with disabilities, and veterans to apply.

We will make reasonable accommodations to all qualified applicants with disabilities. If you are an individual with a disability who needs assistance or cannot access the online job application system, please contact the job information line at 651-259-3637 or email careers@state.mn.us. Please indicate what assistance you need.

SDL2019-256

- **Seniority level**

  Associate

- **Employment type**

  Full-time

- **Job function**

  ConsultingInformation TechnologySales

- **Industries**

  Nonprofit Organization ManagementHigher EducationGovernment Administration

Fallon Health hiring RN Clinical Manager - Growing Elder Service Program - Lowell MA - Fallon Community Health Plan in Lowell, MA

SourceURL: https://www.linkedin.com/jobs/view/rn-clinical-manager-growing-elder-service-program-lowell-ma-fallon-community-health-plan-at-fallon-health-1224296951

Job description

Job ID: 5488

 # Positions: 1

Category: Medical Management

Overview

Product Line:

To Help Serve the Lowell Region we welcome all candidates that also Speak Khmer, Spanish or Portuguese

SUMMIT ELDERCARE (www.summiteldercare.org)

Fallon Health's - Summit Elder Care program one of the largest PACE programs (Program of All-Inclusive Care for the Elderly) in the country and the very first PACE program in the nation to be associated with a Health Plan. Summit ElderCare currently already serves residents of Hampden County, Worcester County, and the communities of Easthampton, Granby, Hudson, Marlborough, Southampton and South Hadley. We help give elderly adults and their caregivers an innovative choice in health care as a welcome alternative to nursing home care. Participants in Summit ElderCare have access to most medical services through a Summit ElderCare site while they keep living in their own homes and communities.

FALLON HEALTH (www.fallonhealth.org)
Founded in 1977, Fallon Community Health Plan is a nationally recognized, not-for-profit health care services organization. From traditional health insurance products available throughout Massachusetts for all populations, to innovative health care programs and services for independent seniors, Fallon Health supports the diverse and changing needs of all those it serves. Consistently ranked among the nation's top health plans, Fallon is the only health plan in Massachusetts to have been awarded "Excellent" Accreditation by the National Committee for Quality Assurance for its HMO, Medicare Advantage and Medicaid products.

Position Overview

Provides program level guidance and recommendations relevant to the provision of clinical and nursing services. Oversees implementation of discipline specific policies and procedures.

Responsible for the operations of the PACE center clinic. Oversees all nursing services provided to the participants at the center. Supervises and directs RNs, LPNs and Health Aides assigned to the ADHC. Functions as the Assistant Program Director as needed/assigned.

Responsibilities

- Assists with recruitment and training of staff within the discipline.
- Participates in the oversight of related contracted vendors.
- Monitors PACE, ADHC and state discipline specific regulations to identify, communicate and when appropriate, implement needed changes.
- Represents the program and related discipline at assigned community and external events upon request.
- Develops and maintain discipline specific competency tools.
- Coordinates the provision of patient care throughout the clinic.
- Collaborates with participants, caregivers, physicians, nurse practitioners and other staff to meet participants' needs.
- Delegates work to nursing staff members according to their scope of practice by establishing work assignments and coordinating staff schedules.
- Participates in all types of Interdisciplinary Team meetings.
- Participates in management and quality meetings as required.
- Collaborates with the Site Director to establish goals and objectives related to the clinical setting.
- Coordinates/supervises the purchase of medical/surgical/pharmaceutical supplies.
- Assures that clinical equipment is in good working condition in collaboration with the Quality and Risk Manager.
- Assumes responsibility for inservice education for nursing staff.
- Interviews potential nursing staff candidates and makes recommendations for hiring to Site Director.
- Conducts new staff orientation and performance evaluations for clinical staff in a timely manner.
- Conducts regular staff meetings with clinical staff.
- Assists with routine nursing duties as required.
- Assures that corrective action plans are completed for incidents related to clinical services.
- Assists the Site Director to carry out administrative duties as needed. Functions as acting Site Director in the Site Director's absence.
- Accepts "on-call" duty on a rotating basis and assists the Site Director with scheduling the rotation.
- Performs all duties in accordance with FCHP and Summit ElderCare policies and procedures.

Qualifications

Education: Graduate of an accredited school of nursing.

BSN strongly preferred.

License: Licensed as an RN in Massachusetts

Certification: CPR certificationor willingness to be certified.

Experience: At least two years of managerial experience working with frail elders in a health care setting.Ambulatory clinic experience is helpful but not essential.

PM16

PI109164697

Director Finance (Medicaid) Insurance - Southfield, MI at Geebo

SourceURL: https://southfield-mi.geebo.com/jobs-online/view/id/729368394-director-finance-medicaid-/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Director Finance (Medicaid)

Responsibilities:

Individual responsible for accounting and finance operations, including all audit activities and for the oversight of the day to day financial operations for the health plan or line of business, including financial planning, reporting, and budget management.

- Coordinates the development of the annual operating plan (AOP) for the health plan or line of business and works with
- Corporate Finance to ensure timely completion of the AOP.
- Monitors budgetary compliance to assure that operational performance results are achieved.
- Works with Corporate Finance to update reforecasts and the strategic plan as needed.
- Develops and monitors cost containment activities for the LOB.
- Provides information to ensure the production of timely, accurate and compliant financial reports that meet all accounting standards, government regulations and federal, state and local laws.
- Provides ad hoc financial support to senior management, middle management, and corporate departments as needed.
- Acts as a primary liaison for interaction/communication with the State Finance personnel as necessary
- May manage the facilities function for the site.
- May manage one or more of the following staff: financial analysts and facility management specialists.

Education/Experience:

- Required: Bachelor s Degree in Accounting.
- Required: 3-5 years Management experience.
- Required: 7 or more years of Financial/ Cost Accounting.
- Required: Familiarity with healthcare insurance reporting and regulation.
- Required: Demonstrated analytical, financial analysis and planning skills.
- Required: Demonstrated understanding of GAAP reporting, treasury operations, corporate taxation and legal principles.
- Preferred: CPA preferred.

Centene Corporation hiring Transition Nurse RN in San Bernardino, CA

SourceURL: https://www.linkedin.com/jobs/view/transition-nurse-rn-at-centene-corporation-1186311426

Apply on company website

Job description

HourlyPosition Purpose The Transition Nurse is responsible for identifying, overseeing and managing coordination for health plan members during changes or transitions between contracted programs and providers within an assigned region.

- Manages plan change transition activities including Identifying members with special health care needs requiring transition and coordinate all activities required to successfully transition the member to or from Health Net
- Ensures that transition activities are accomplished in accordance with applicable health plan/program contractor policies and procedures
- Acts as an advocate for members leaving and joining the health plan/program
- Interacts with personnel at all levels with external health plan and program contractors to facilitate communication between impacted parties, including health plan/program contractors and federal programs
- Assists PCPs, internal health plan/program departments, and other contracted providers with the coordination of care for transitioning members
- Ensures that continuity and quality of care for transitioning members is maintained during health plan/program contractor transitions
- Participates in transition planning meetings
- Makes recommendation to management in regards to developing transition policy
- Assists with translation of contract requirements into recommendations for internal policies and procedures
- Performs other duties as required.
  Education/Experience Graduate of an accredited nursing program. Bachelor's Degree Preferred. Minimum three years clinical experience. Minimum five years managed care experience, including Case Management, Utilization Management, and/or Discharge planning. Experience working in a Managed Care Health Plan environment including Medicare / Medicaid. Experience with development of policies and procedures.

  License/Certification Current, valid and unrestricted RN Licensure Required. Certified Case Manager preferred.

  Centene is an equal opportunity employer that is committed to diversity, and values the ways in which we are different. All qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, disability, veteran status, or other characteristic protected by applicable law.

- **Seniority level**

  Not Applicable

- **Employment type**

  Full-time

- **Job function**

  Health Care Provider

- **Industries**

The Children's Village hiring Medicaid Behavioral Health Services Manager in Dobbs Ferry, NY

SourceURL: https://www.linkedin.com/jobs/view/medicaid-behavioral-health-services-manager-at-the-children-s-village-1220416252

Apply on company website

Job description

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.

Qualifications

Education

Required

- Bachelors or better

State of Louisiana hiring MEDICAID PROGRAM MANAGER 4 (Medicaid EPO Section Chief) in Baton Rouge, LA

SourceURL: https://www.linkedin.com/jobs/view/medicaid-program-manager-4-medicaid-epo-section-chief-at-state-of-louisiana-1221786661

Apply on company website

Job description

Supplemental Information
Job #: MVA/KDC/1029
This position is located within the LA. Department of Health/MVA/Eligibility/East Baton Rouge Parish.
Cost Center: 305-7208
Position #: 50531090
This vacancy is being announced as a classified position and may be filled as a Job Appointment or Detail.
(Job Appointments are temporary appointments that may last up to 48 months)

Working Job Description

The Louisiana Medicaid Program, which provides healthcare services to low income individuals, has an annual budget of approximately $12.9 billion dollars, a staffing complement of almost 900 authorized employees and almost 500 contracted direct-support staff, and provides services to approximately 1.7 million enrollees annually. The program is a state of federal partnership financed with a combination of state and federal funds and governed by a complex body of state and federal laws, policies, regulations, and guidelines. The Eligibility program is administered statewide in eight (8) geographical regions through State, Regional and Parish offices.
This Section Chief position administers the statewide Medicaid Eligibility Program Operations (EPO) within the Louisiana Department of Health (LDH), Bureau of Health Services Financing (BHSF). The incumbent provides the highest administrative and managerial services, by planning, organizing, implementing, and directing the EPO Section in relation to the overall operation of the Louisiana Medicaid's statewide eligibility program.
The EPO Section Chief will work collaboratively with the Eligibility Field Operations (EFO) Section Chief as the programs under the incumbent's purview has a direct impact on the processes and procedures of the eligibility staff in the eight (8) regions. The incumbent directs and monitors complex tasks at the State level with, without intervention, could jeopardize agency federal funding, cause federal sanctions, cause loss of state dollars, and cause Department or State legal liabilities. Assures Eligibility policy and procedures aligns with goals and mission of the Department to the community, clientele, staff, providers, Applications Centers and federal officials.
Directs activities and prepares ongoing work plans for subordinate program managers under incumbent's purview. Establishes work schedules and priorities to ensure that the activities under incumbent's scope of supervision are performed in a timely and efficient manner. Supervises and directs work of subordinate staff, establishing performance goals, objectives, and evaluation criteria for employee performance. Schedules and participates in periodic performance reviews and planning conferences and completes formal performance appraisal. Identifies staff development needs and ensures that appropriate training is obtained. Conducts staff meetings

and conferences to disseminate information and provides expertise and guidance on work assignments, policy, special projects and technical problems.
No Civil Service test score is required in order to be considered for this vacancy.
To apply for this vacancy, click on the "Apply" link above and complete an electronic application which can be used for this vacancy as well as future job opportunities. Applicants are responsible for checking the status of their application to determine where they are in the recruitment process by selecting the 'Applications' link after logging into their account. Below are the most common status messages and their meanings.
Application received - Your application has been submitted successfully.
Evaluating experience - Your application is being reviewed to ensure you meet the minimum qualifications for the position.
Minimum Qualification Review - See History - Click the History link for the results of your application review. Passing candidates will designate as "Pass". Failing candidates will designate as "Fail".
Eligible for consideration - You are among a group of applicants who MAY be selected for the position.
Eligible Pending Supplemental Qualification Review - Only candidates meeting the supplemental qualification will be eligible for referral.
Referred to hiring manager for review - Your application has been delivered to the hiring manager. You may or may not be called for an interview.
Position filled - Someone has been selected for the position.
Position canceled - The agency has decided not to fill the position.
The State of Louisiana only accepts online applications. Paper applications will not be accepted. Computer access is available at your local library, at local Louisiana Workforce Commission Business Career Solutions Centers, and at the State Civil Service Testing and Recruiting Center at 5825 Florida Boulevard, Room 1070, Baton Rouge, LA 70806. If you require an ADA accommodation, please contact our office at (225) 925-1911 or Toll Free: (866) 783-5462 during business hours for additional assistance.
(Please note: Libraries and LWC centers cannot provide in-depth assistance to applicants with limited computer skills; therefore, we suggest that such applicants have someone with computer proficiency accompany them to these facilities to assist with the computer application process. Also, no State Civil Service employees are housed at the libraries or LWC centers to answer specific questions about the hiring process. Such questions should be directed to the State Civil Service Testing and Recruiting Center at the phone numbers above or by visiting the office on Florida Blvd. where assistance is available. Information is also provided on our job seeker website at https://jobs.civilservice.louisiana.gov/).

For Further Information About This Vacancy Contact

Kelsi Chaney
LDH/Human Resources
P.O. Box 4818, Baton Rouge, LA 70821
Kelsi.Chaney@la.gov
This organization participates in E-verify, and for more information on E-verify, please contact DHS at 1-888-464-4218.

Qualifications

MINIMUM QUALIFICATIONS:

A baccalaureate degree plus five years of professional experience in administrative services, economics, public health, public relations, statistical analysis, or in providing social services or health services. Two years of this experience must have been at the supervisory level or above.

Substitutions

Six years of full-time work experience in any field may be substituted for the required baccalaureate degree.

Candidates without a baccalaureate degree may combine work experience and college credit to substitute for the baccalaureate degree as follows:
A maximum of 120 semester hours may be combined with experience to substitute for the baccalaureate degree.
30 to 59 semester hours credit will substitute for one year of experience towards the baccalaureate degree.
60 to 89 semester hours credit will substitute for two years of experience towards the baccalaureate degree.
90 to 119 semester hours credit will substitute for three years of experience towards the baccalaureate degree.
120 or more semester hours credit will substitute for four years of experience towards the baccalaureate degree.
College credit earned without obtaining a baccalaureate degree may be substituted for a maximum of four years full-time work experience towards the baccalaureate degree. Candidates with 120 or more semester hours of credit, but without a degree, must also have at least two years of full-time work experience tosubstitute for the baccalaureate degree.
Graduate training with eighteen semester hours in one or any combination of the following fields will substitute for a maximum of one year of the required general experience on the basis of thirty semester hours for one year of experience: public health; public relations; counseling; social work; psychology; rehabilitation services; economics; statistics; experimental/applied statistics; business, public, or health administration.
A master's degree in the above fields will substitute for one year of the required general experience.
A Juris Doctorate will substitute for one year of the required general experience.
Graduate training with less than a Ph.D. will substitute for a maximum of one year of required general experience.
A Ph.D. in the above fields will substitute for two years of the required general experience.
Advanced degrees will substitute for a maximum of two years of the required general experience.

Note

Any college hours or degree must be from a school accredited by one of the following regional accrediting bodies: the Middle States Commission on Higher Education; the New England Association of Schools and Colleges; the Higher Learning Commission; the Northwest Commission on Colleges and Universities; the Southern Association of Colleges and Schools; and the Western Association of Schools and Colleges. Job Concepts

Function Of Work

To serve as the Section Chief administering all functions of large and complex Medicaid program(s).

Level Of Work

Administrator.

Supervision Received

Administrative direction from a higher-level administrator/executive.

Supervision Exercised

Supervision over lower-level positions in accordance with the Civil Service Allocation Criteria Memo.
Location of Work:
Department of Health and Hospitals.

Job Distinctions

Differs from Medicaid Program Manager 3 by serving as the Section Chief administering all functions of large and complex Medicaid program(s) and supervision exercised.
Differs from Medicaid Deputy Director by the absence of responsibility for the day-to-day management of Medical Vendor Administration.
Examples of Work
Serves as an assistant to the Medicaid Deputy Director and may direct agency in the absence of the Medicaid Deputy Director.
Administers comprehensive statewide Medicaid programs by formulating and implementing current and long-range plans, policies, procedures and regulations.
Participates in Medicaid budget planning, preparation, and grant administration.
Conducts investigations and makes recommendations for the Medicaid Director's response to grievances by Field Operations staff.
Monitors statewide field operations to determine the efficiency and effectiveness of the delivery of Medicaid Eligibility services.
Develops, monitors, and administers various methodology reimbursement policies.
Represents the Department in programmatic matters at various federal, state and local hearings, meetings, and conferences.
Monitors policies and procedures to ensure that policies and system requirements comply with the law and federal regulations.
Works closely with state, regional, and parish administrative staff in developing management procedures and operational plans to assure that all agency programs are implemented at the field operations level as intended by federal and state laws and regulations.
Coordinates with state level administrative and support staff to improve program development, identify staff training needs and provide management and support services required and needed by department staff.

Presbyterian Healthcare Services hiring CLAIMS QUALITY SPEC - MEDICAID CLAIMS in Albuquerque, NM

SourceURL: https://www.linkedin.com/jobs/view/claims-quality-spec-medicaid-claims-at-presbyterian-healthcare-services-1221470433

Apply on company website

Job Description

Type of Opportunity: Full Time
FTE: 1.000000
Exempt: No
Work Schedule: Days

Summary

Responsible for reviewing payable and denied medical and facility claims for the Interagency Task Force Groups (ITF) ASO to measure accuracy of the claims processing function as determined by benefit plan design, provider agreements, and applicable health claims policies and procedures as defined and adopted by Presbyterian Health plan

Responsibilities

Responsibilities

- Review payable and denied claims and claim adjustments processed by Analysts and Specialists for the ITF/ASO plan. Claims will be reviewed for procedural and financial accuracy.
- Identify and propose changes to current processing guidelines to maintain ASO quality standards.
- Identify and prepare adds, changes, and deletions to Acrobat.
- Identify and propose add, changes, and deletions between Acrobat and benefit configuration.
- Identify and propose adds, changes, and deletions between ITF/ASO contracts and Summary Plan Descriptions (SPD s) and Acrobat.
- Identify claims processing guidelines and policies that require review and clarification, and communicate those issues to the D.A.T.A. Team and Training Department.
- Identify provider billing practices that are inconsistent with Presbyterian Health Plan contractual agreements and communicate those issues to the Provider Relations Departments for follow-up with the provider.
- Identifies patterns in payable, denied and adjusted claims. Identifies errors and inconsistencies that require revisions to claim guidelines, system modifications, or Analyst and Specialist practices.
- Performs tasks individually and as part of an assigned team.
- Participates as an effective and active team member.
- Act as liaison between ITF account regulators/auditors and PHP staff.

Requirements

Qualifications

High school education (G.E.D.) required. 5 years of experience in claims processing required. Demonstrated ability to communicate effectively in person, via telephone and in writing. Demonstrated ability to sustain quality and production standards. Requires good organization skills, and the ability to analyze reports and system processes. Demonstrated ability to function effectively as a team member

Essential

Education:

- High School Diploma or GED

Nonessential

Competencies and skills:

- SKILL-10-KEY
- Analytics skills
- SKILL-Medical Claims Processing
- Coaching skills
- SKILL-Critical thinking and attention to detail.
- Communicating with Individuals & Groups
- Flexibility and adaptability quickly to new/different environments and situations
- Mentoring/Developing an Associate
- Working well with diverse personalities and managing styles
- SKILL-Data Entry
- SKILL-Decision Making
- SKILL-Accuracy and attention to detail are crucial
- FACETS
- ICD 9 OR 10
- SKILL-Medical Terminology

- SKILL-Microsoft Office
- SKILL-Must be able to effectively manage multiple priorities in a fast-paced environment.
- Applying Analytical and Planning Skills
- Adapting and responding to a Changing Circumstance
- Building Customer confidence by increasing satisfaction, achieving expectations, and ensuring commitments are met
- Demonstrating integrity and ethics in day-to-day tasks and decision making
- Educating Employees, Customers & Transferring Knowledge
- Participating in necessary meetings and conference calls
- Diagnosing & Resolving Problems
- Applying Superior Skills to Achieve Staffing and Service Levels / Quality Outcomes
- Acquiring & Applying Superior Skills to achieve Quality Outcomes
- Functioning as an Effective Team Member
- Organizational Skills
- Organizational Skills
- SKILL-Prioritize and manage a high volume workload.
- Demonstration of high degree of independent problem solving and critical thinking skills.
- SKILL-Read/Write English-Follow directions
- SKILL-Ability to pull detail reports out of systems.
- SKILL-Demonstrate ability to work effectively in a team environment
- Typing skill
- SKILL-Demonstrated ability to communicate effectively in person and via telephone with members, employer groups, brokers, physicians, and physician office staff using strong dialogue and customer service competencies.
- SKILL-Able to work under limited supervision, self manage work time and projects, resolve issues with minimal assistance.
- SKILL-Written communication

Benefits

Benefits

Benefits are effective day-one (for .45 FTE and above) and include:

- Competitive salaries
- Full medical, dental and vision insurance
- Flexible spending accounts (FSAs)
- Free wellness programs
- Paid time off (PTO)
- Retirement plans, including matching employer contributions
- Continuing education and career development opportunities
- Life insurance and short/long term disability programs

About Us

Presbyterian Healthcare Services is a locally owned, not-for-profit healthcare system of nine hospitals, a statewide health plan and a growing multi-specialty medical group. Founded in New Mexico in 1908, it is the state's largest private employer with approximately 11,000 employees.

Presbyterian's story is really the story of the remarkable people who have chosen to work here. Starting with Reverend Cooper who began our journey in 1908, the hard work of thousands of physicians, employees, board members, and other volunteers brought Presbyterian from a tiny tuberculosis sanatorium to a statewide healthcare system, serving more than 700,000 New Mexicans.

We are part of New Mexico's history - and committed to its future. That is why we will continue to work just as hard and care just as deeply to serve New Mexico for years to come.

About New Mexico

New Mexico's unique blend of Spanish, Mexican and Native American influences contribute to a culturally rich lifestyle. Add in Albuquerque's International Balloon Fiesta, Los Alamos' nuclear scientists, Roswell's visitors from outer space, and Santa Fe's artists, and you get an eclectic mix of people, places and experiences that make this state great.

Cities in New Mexico are continually ranked among the nation's best places to work and live by Forbes magazine, Kiplinger's Personal Finance, and other corporate and government relocation managers like Worldwide ERC.

New Mexico offers endless recreational opportunities to explore, and enjoy an active lifestyle. Venture off the beaten path, challenge your body in the elements, or open yourself up to the expansive sky. From hiking, golfing and biking to skiing, snowboarding and boating, it's all available among our beautiful wonders of the west.

AA/EOE/VET/DISABLED. PHS is a drug-free and tobacco-free employer with smoke free campuses.

Centers for Medicare & Medicaid Services hiring Pharmacist in Gwynn Oak, MD

SourceURL: https://www.linkedin.com/jobs/view/pharmacist-at-centers-for-medicare-medicaid-services-1213241462

Apply on company website

Job description

Pharmacist Needed, Centers for Medicare & Medicaid Services!!- Competitive Salaries and flexible schedules!!

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

As a Pharmacist, you will provide clinical pharmacy expertise and guidance in support of one or more CMS program policy or support teams.

As a **Supervisory Health Insurance Specialist (Director)**, you will be responsible for directing a staff in the successful implementation and operation of preventive care and population health delivery models.

Responsibilities

- Provide technical assistance as a professional pharmacist to interpret, monitor, or evaluate program guidance about CMS programs (e.g., Medicare Part B, Medicare Part D, or Medicaid).
- Translate the results of studies into actionable recommendations that inform current and future agency policies and processes.
- Evaluate Medicare Part D prescription drug benefit design and formulary submissions; working with CMS actuaries or actuarial contractors to develop the pharmaceutical-

actuarial analysis of selected Medicare prescription drug plan bids.
- Develop, monitor, and evaluate regulations, policies, procedures, and other guidelines for States in the design and implementation of their Medicaid prescription drug programs.

Qualifications

All candidates must possess the following license/registration: **Applicants must be licensed to practice pharmacy in a State, the District of Columbia, the Commonwealth of Puerto Rico, or a territory of the United States..Proof of Licensure/Registration is required** at the time of application to verify possession of the license/registration listed above. Please see the "Required Documents" section of the full vacancy announcement for more details on which documents to submit.

Additionally, you must have at least one year of specialized experience in the following areas:

1) Evaluating prescription drug benefits and formulary submissions.

2) Analyzing pharmacy administrative claims.

3) Identifying vulnerabilities to detect, prevent and deter fraud in pharmaceutical programs.

How do I apply?

Click the "apply" button to visit the full vacancy announcement for more details.

Your complete application package, as described in the "Required Documents" section of the vacancy announcement, must be received by 11:59 PM ET on 04/17/2019 to receive consideration.

- **Seniority level**

  Associate

- **Employment type**

  Full-time

- **Job function**

  AnalystConsultingStrategy/Planning

- **Industries**

  Government Administration

Steward Health Care System hiring Senior Analyst, Medicaid ACO in Needham, MA

SourceURL: https://www.linkedin.com/jobs/view/senior-analyst-medicaid-aco-at-steward-health-care-system-1220190435

Apply on company website

Job description

Job Description

POSITION SUMMARY:

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

Key Responsibilities

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

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

Required Knowledge & Skills

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

Education/Experience/Licensure/Technical/Other

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

- **Seniority level**

  Associate

- **Employment type**

  Contract

- **Job function**

  ResearchAnalystInformation Technology

- **Industries**

  Nonprofit Organization ManagementHealth, Wellness and FitnessHospital & Health Care