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Medicaid Jobs Hunter

In this packet....

Health Care Cost Containment hiring PUBLIC HEALTH NURSING CONSULTANT in Phoenix, AZ, US

Accountability, Community, Innovation, Leadership, Passion, Quality, Respect, Teamwork

Public Health Nursing Consultant

This position will remain open until filled.

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.

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Job Summary

The **Division of Health Care Management (DHCM)** is looking for a highly motivated individual to join our team as a Public Health Nursing Consultant. The position is responsible for understanding the needs of stakeholders especially those of members with unmet health care needs, members diagnosed with a Serious Mental Illness (SMI) or other behavioral health conditions, members diagnosed with development delays, members with special health care needs, and families of children with special health care needs. This position will work directly with ALTCS, Acute, foster care (CMDP), CRS, DDD, AIHP, and RBHA quality management areas; however, the primary focus will be on cases involving behavioral health conditions. Major duties and responsibilities include but are not limited to:

- Receive, research, document, and resolve quality of care issues utilizing standardized processes and centralized databases. Track, trend, and monitor status of cases to ensure thorough and timely completion as well as appropriate referrals. Primary emphasis will be placed on special populations such as those utilizing behavioral health services. Ensure research and resolution of quality of care issues in a timely manner as assigned and identify systemic issues for AHCCCS to address.
- Participate in operational reviews, technical assistance, and focused studies/reviews, including the behavioral health delivery system, to ensure compliance with contractual and policy requirements for all lines of business. Follow-up on written reports, corrective action plans, notices to cure and sanctions as appropriate.
- Ensure quality of care to AHCCCS members, including ensuring member health and safety as well as dignity and respect. Focus on unique aspects of each case, individual care needs, timely correspondence with members, and timely acknowledgment of concerns as well as resolution of the issue. Use appropriate judgment regarding data to research, regulatory referrals, status level, interventions, and appropriate resolution.
- Participate in special projects and reviews as assigned and assure completion within the designated timelines. Provide ongoing updates to leadership.
- Coordinate and complete tracking, evaluation and responses to Contractor deliverables.
- Provide technical assistance to Contractors and FFS providers, as appropriate, regarding contractual and/or policy requirements to improve quality of care and service delivery to AHCCCS members.

- Participate in individual and ongoing meetings, including agendas, attainment of speakers, minutes and resulting actions and activities.
- Participate in the development of improved processes and procedures to improve efficiency of the QM Unit.
- Participate in peer review processes including presentation of challenging and high profile cases, and initiate resolution activities as directed by the AHCCCS Chief Medical Officer.

KNOWLEDGE, SKILLS AND ABILITIES (KSAs)

- Demonstrated knowledge of State and Federal Policies and Procedures governing Title XIX, Title XXI,Managed Care, Behavioral Health, LTC and Tribal and Children's Rehabilitative Services
- Demonstrated knowledge of Medical/nursing practice, medical case management protocols, utilization review protocols as related to assigned populations (e.g. Acute, behavioral health, Long Term Care)
- Knowledge of techniques to select a particular approach to analyze, develop or implement a policy, Project management methodologies and Behavioral Health delivery system.
- Strong interpersonal skills in order to effectively relate to AHCCCS members, their families, and Agency stakeholders.
- Skilled in acute nursing processes including assessment, planning, intervention and evaluation
- Understanding of and experience with special health care needs populations.
- Strong ability to assess members from a holistic perspective with an emphasis on recognizing medical, social, environmental and emotional conditions, barriers for meeting medical needs that interfere with the member's ability to function at an optimal level.

Selective Preference(s)

- Certified Professional in Healthcare Quality
- At least one year experience working in a managed care environment
- Case Management and/or social work experience

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 click apply 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.

Click the APPLY NOW button to submit your application.

For technical assistance, email click apply or call click apply.

- **Seniority level**

  Associate

- **Employment type**

  Full-time

- **Job function**

  Other

- **Industries**

  InsuranceGovernment AdministrationHospital & Health Care

Fallon Community Health Plan Clinical Assistant - Growing Elder Care Services Program - L Job in Leominster, MA

SourceURL: https://www.glassdoor.com/job-listing/clinical-assistant-growing-elder-care-services-program-l-fallon-community-health-plan-JV_IC1154913_KO0,56_KE57,85.htm?jl=3230343846

Clinical Assistant - Growing Elder Care Services Program - L

Fallon Community Health Plan
Applied 5/13/19
Fallon Community Health Plan is actively hiring on Glassdoor

Clinical Assistant - Growing Elder Care Services Program - Leominster, MA

US-MA-Leominster

Job ID: 5570
Type: Full Time
# of Openings: 1
Category: Care Coordination
Summit ElderCare - Leominster

Overview

About Fallon Health Founded in 1977, Fallon Health is a leading health care services organization that supports the diverse and changing needs of those we serve. In addition to offering innovative health insurance solutions and a variety of Medicaid and Medicare products, we excel in creating unique health care programs and services that provide coordinated, integrated care for seniors and individuals with complex health needs. Fallon has consistently ranked among the nation's top health plans, and is accredited by the National Committee for Quality Assurance for its HMO, Medicare Advantage and Medicaid products. For more information, visit fallonhealth.org. About Summit ElderCare: Fallon Health operates the largest Program of All-Inclusive Care for the Elderly (PACE) in New England and the fifth largest in the country. Called Summit ElderCare, Fallon's PACE helps provide older adults and their caregivers with a welcome alternative to nursing home care. Participants in Summit ElderCare have access to comprehensive

medical services and social support at a Summit ElderCare site while they keep the independence of living in their own homes and communities. Position Overview: The clinical assistant performs clinical and administrative duties under the direction of the Clinical Nurse Manager, assists the MD/DO, NP and/or RN in administering care and treatment to participants including but not limited to phlebotomy and EKG in an expeditious, courteous and professional manner, facilitating a smooth flow of healthcare practices, providing basic and direct care to participants as directed, and ensuring a good patient care experience in the PACE clinic.

Responsibilities

Verifies patient information by interviewing patient; recording medical history; confirming purpose of visit.Prepares patients for examination by performing preliminary physical tests; taking baseline vitals; reporting patient history summary.Secures patient information and maintains patient confidentiality by completing and safeguarding medical records; completing diagnostic coding and procedure coding; keeping patient information confidential.Maintains safe, secure, and healthy work environment by establishing and following standards and procedures; complying with legal regulations.Keeps supplies ready by inventorying stock and reporting to Clinical Manager when below PAR levels; Keeps equipment operating by following operating instructions; troubleshooting breakdowns; maintaining supplies; performing preventive maintenance; calling for repairs. Updates job knowledge by participating in continuing educational opportunities; reading professional publications. Serves and protects the medical practice by adhering to professional standards, policies and procedures, federal, state, and local requirements.Demonstrates an ability to relate well to participants; anticipates their needs and encourages independence.Assists participants with personal care needs such as dressing, toileting, bathing, grooming and other needs as identified in the care plan.Carries out clinical tasks such as assessment of vital signs, urine testing, foot care, simple dressings, catheter care, CD bag changes, hot packs and delivery of laboratory specimens.Assists participants in completion of PT/OT maintenance therapy program including, but not limited to, exercises and ambulation, as assigned.Documents all care rendered in the electronic medical record.Works as a member of the clinical team to provide high quality, timely service to patients.Prepares patient for examination by the PACE medical provider. Identifies and reports emergency situations to nursing and provider personnel, applies first aid as necessary and assists as his/her competency will allow.Provides care appropriate to patient population served.Utilizes knowledge to provide services under established organization and department policies and proceduresReviews, understands, and adheres to all department policies and procedures.Tracks all lab requests and future lab draws.Final lab copies are given to designated provider.Obtains routine and emergency blood samples by veni-puncture in accordance with established quality control procedures both at the PACE center and in the participant's home, as needed.Tracks all results and charts labs in the electronic medical record.

Qualifications

Education: High School Diploma, completion of qualified phlebotomy course and internship required Certification: Medical Assistant. CPR, EKG and Phlebotomy Certification (within 1 year of employment) Experience: Minimum 1 year working with elderly population JT18 PI109659264 Pandologic. Keywords: Clinical Assistant, Location: Leominster, MA - 01453

Fallon Community Health Plan RN Nurse Case Manager - Looking for Spanish Speaking Nurse - Worcester, MA

SourceURL: https://www.glassdoor.com/job-listing/rn-nurse-case-manager-looking-for-spanish-speaking-nurse-t-fallon-community-health-plan-JV_IC1154962_KO0,58_KE59,87.htm?jl=3230407833

Fallon Community Health Plan
Applied 5/13/19
Today
Fallon Community Health Plan is actively hiring on Glassdoor

RN Nurse Case Manager - Looking for Spanish Speaking Nurse to join our great team!!

US-MA-Worcester

Job ID: 5549
Type: Full Time
# of Openings: 1
Category: Nursing
Fallon Health - Corp HQ

Overview

About NaviCare: Fallon Health is a leader in providing senior care solutions such as NaviCare, a Medicare Advantage Special Needs Plan and Senior Care Options program. Navicare integrates care for adults age 65 and older who are dually eligible for both Medicare and MassHealth Standard. A personalized primary care team manages and coordinates the NaviCare member's health care by working with each member, the member's family and health care providers to ensure the best possible outcomes. About Fallon Health Founded in 1977, Fallon Health is a leading health care services organization that supports the diverse and changing needs of those we serve. In addition to offering innovative health insurance solutions and a variety of Medicaid and Medicare products, we excel in creating unique health care programs and services that provide coordinated, integrated care for seniors and individuals with complex health needs. Fallon has consistently ranked among the nation's top health plans, and is accredited by the National Committee for Quality Assurance for its HMO, Medicare Advantage and Medicaid products. For more information, visit fallonhealth.org. Brief Summary of purpose: The Nurse Case Manager Purpose is to: Assess a member's clinical/functional/behavioral health status and use this information to provide case management and care coordination for the member across the continuum of care which is consistent with a member's health care needs and goalsSupport members at time of care transition, advocating at time of discharge and facilitation with the primary care team to ensure the care plan is effective to meet care needs teaching about disease process, medications, and other strategies as requiredCollaborating with all members of the primary care team, the member, designated care givers, and others involved in the member careAssess members for long term services and supports and apply coverage criteria to determine level of care and number of hours for programs such as personal care attendant, group adult foster care, adult foster care, short term custodial care, and other long term services in supports in collaboration with the Aging Service Access Point staff, long term care facilities, and members of the primary care teamCommunicate with primary care providers and other medical and service providers about a member's clinical status and needsDocument all actions/assessments/care coordination in the documentation system according to Program Policy and ProcessComplete regulatory mandates per requirements including but not limited to Health Risk Assessments, Care Plans, MDS HC assessments and submissions in the State Virtual GatewayStrictly observes HIPAA regulations and the Fallon Health Policies regarding confidentiality of member information

Responsibilities

Member Assessment, Education, and Advocacy In collaboration with the NaviCare Outreach Team, works to facilitate a smooth new member onboarding experience and provides excellent customer service at all times Conducts in home face to face visits to assigned community dwelling members with member's consent. Visits may be by self, or with others of the Primary Care Team Utilizing clinical judgment and nursing assessment skills, completes the Program Health Risk Assessment Tools and Minimum Data Set Home Care (MDS HC) Form within the first month of enrollment, and at intervals defined by the Program ensuring members are in the correct State defined rating categoryDemonstrates knowledge of the NaviCare benefits and applies coverage criteria, payment policy, and MassHealth guidelines when developing and implementing member care plans teaching members and other members of the primary care team about benefits, qualifications, and coverage criteriaUtilizes a variety of interviewing techniques, including motivational interviewing, and employs culturally sensitive strategies to engage and work with membersAssesses the Member's knowledge about the management of current disease processes and medication regimen and provides teaching to increase Member/caregiver knowledgeEducates the member/caregivers to ensure enhancement of effective self-management skills and educates and provides caregiver education and supportAssesses members at time of care transition and completes assessmentsEnsures members/PRAs participate in the development and approval of their care plans in conjunction with the interdisciplinary primary care team Care Coordination and Collaboration Provides culturally appropriate care coordination, i.e. works with interpreters, provides communication approved documents in the appropriate language, and demonstrates culturally appropriate behavior when working with member, family, caregivers, and/or authorized representativesManages complex community members in the AD/CMI' and Nursing Home Certifiable' rating categories in conjunction with the Navigators, Behavioral Health Case Managers, Aging Service Access Point Geriatric Support Service Coordinators, contracted Primary Care Providers and others involved/authorized in the member's careWith member/authorized representative(s) collaboration develops member centered care plans by identifying member care needs while completing program assessments and developing care plans working with the Navigator to ensure the member approves their care planMonitors progression of member goals and care plan goals, provides feedback and works collaboratively with care team members and work effectively in a team model approach to coordinate a continuum of care consistent with the Member's health care goals and needs Care Transitions per Program Processes: Works closely with the Navigator, who closely monitors the daily inpatient census, to learn when the member has a care transition Communicates and coordinates member care needs and discharge plans with Fallon Health Utilization Management staffParticipates in discharge planning meeting at the facility to ensure member care needs are met before and after dischargeFollows up with member/PRA telephonically or in person after discharge to perform Transition of Care assessment, medication reconciliation, and ensure services are in place as care planned within designated time frames Works collaboratively with Fallon Health Pharmacist, referring members in need of medication review based upon Program processDevelops and fosters relationships with members, family, caregivers, PRAs, vendors and providers to ensure good collaboration and coordination by streamlining the focus of the Member's healthcare needs utilizing the most optimal treatment approach, promoting timely provision of care, enhancing quality of life, and promoting cost-effectiveness of care Collaborates with Navigators who manage the Community Well' members and performs clinical care transition assessments and other health risk assessments when members experience a care transition or other triggers that warrant an assessment of rating category status always involved with any clinical' issues and care coordination needs for this population Reviews and validates data on Member Panel report generated from TruCare and takes action to ensure accurate data Regulatory Requirements Actions and Oversight Completes Health Risk Assessments, Minimum Data Set Home Care (MDS HC) Assessments, Transition of Care Assessments, and Care Plans in the Centralized Enrollee Record and Virtual Gateway according to Regulatory Requirements and Program policies and processes Reviews member claims and available reports to determine if a change in status may warrant MDS HC submission to the Virtual Gateway facilitating the appropriate State rating categoryKnowledge of and compliance with HEDIS and Medicare 5 Star measure processes, performing member education,outreach, and actions in conjunction with the Navigator Provider Partnerships Collaboration Work with Fallon Health Teams Demonstrates knowledge of the NaviCare benefits and coverage criteria and fosters collaborative working relationships with

vendor and provider staff Demonstrates positive customer service actions and works with the Navigators and Behavioral Health Case Managers to ensure member and provider requests and needs are met When invited by Outreach/Provider Relations/NaviCare Clinical Leadership Team attends and contributes Model of Care trainings/orientations with providers and/or vendors explaining the various roles of the clinical team in coordination of member's care Performs and may lead face to face or in-person member care plan review with providers including but not limited to Primary Care Providers, Aging Service Access Point Providers, Long Term Services and Support Providers, Behavioral Health Providers, Long Term Care Facility Providers, and/or any other Provider/Member/Authorized Representatives to ensure effective communication and collaboration between all involved May be embedded in certain Provider Facilities and works collaboratively with Provider Facility staff maintaining professional communications and educates about NaviCare benefits, coverage criteria, enrollment requirements and other Program related details Partners with interdepartmental teams (including but not limited to: Utilization Management, Appeals and Grievance, NaviCare Operations, Provider Relations, Pharmacy, Behavioral Health Leadership) within Fallon Health to ensure provider/member satisfaction is maintained while articulating issues to help to facilitate problem/issue resolution

Qualifications

Education: Graduate from an accredited school of nursing mandatory and a Bachelors (or advanced) degree in nursing or a health care related field preferred. License: Active, unrestricted license as a Registered Nurse in Massachusetts; current Driver's license and a vehicle to be used for home visits Certification: Certification in Case Management strongly desired Other: Satisfactory Criminal Offender Record Information (CORI) results A minimum of two years of clinical experience as a Registered Nurse managing chronically ill/geriatric patients or experience in a coordinated care program servicing the needs of elders preferred. Working with Non-English speaking elder populations preferred. Demonstrates proficiency including but not limited to: Ability to assess a member's activities of daily function and independent activities of daily function and the ability to develop and implement a care plan that meets the member's need Work with an interdisciplinary care team as a partner demonstrating respect and value for all roles and is a positive contributor within job role scope and dutiesAbility to organize, schedule, and prioritize to meet the requirements of the positionEffective case management and care coordination skillsKnowledge about community resources, levels of care, criteria for levels of care and the ability to appropriately develop and implement a care plan following regulatory guidelines and level of care criteria Exceptional customer service skills and willingness to assist ensuring timely resolutionKnowledge about geriatric medical concerns, issues, and needsPhysician and other health care provider interaction and other communication including but not limited to face to face communication Ability to effectively respond and adapt to changing business needs and be an innovative and creative problem solverIndependent learning skills and success with various learning methodologies including but not limited to: self-study, mentoring, classroom, and group education Software systems including but not limited to Microsoft Office Products Excel, Outlook, and Word JT18 PI109659267 Pandologic. Keywords: Medical Case Manager, Location: Worcester, MA - 01608

Health Care Cost Containment hiring HEALTH PROGRAM MANAGER 2 in Cottonwood, MN, US

SourceURL: https://www.linkedin.com/jobs/view/health-program-manager-2-at-health-care-cost-containment-1267474822

Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid Agency, is driven by the passion to deliver comprehensive 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.

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Job Summary

The **Division of Member Services (DMS)** is looking for a highly motivated individual to join our team as a Health Program Manager 2 for the Cottonwood ALTCS Office. This position directly supervises and manages a staff consisting of nurses, social workers, program services evaluators, customer service representatives, and supervisors who are responsible for the administration of the AHCCCS Long Term Care (ALTCS), Medicare Cost Sharing (MCS) and Supplemental Social Security Income Medical Assistance Only (SSI MAO) programs. Major duties and responsibilities include but are not limited to:

- Insure that uniform interpretations and application of State and Federal laws, agency policies and rules and regulations governing ALTCS, MCS and MA-SP programs and other related program activities are maintained.Resolving eligibility problems/complaints or refer them to Central Office for resolution if resolution not possible at office.
- Monitor the quality and timeliness of medical and financial eligibility determinations. Preparing reports and providing recommendations and following up with staff on QC and QA findings. Conducting research to keep current in the area of error-reduction strategies.Developing corrective action plans in response to quality findings and the timeliness of eligibility determinations.
- Assign tasks and monitor their completions.
- Monitor regional/branch fair hearing requests and assuring staff participation and preparation
- Conduct regular unit meetings to ensure information is given to staff in a timely manner,attending staff meetings. Conduct regular conferences with direct reports.
- Create and maintain an atmosphere in support of division/agency vision and culture resulting in high morale and employee involvement.
- Participate in problem solving and/or planning work groups. Conducting orientation and on the job training for financial and medical eligibility staff.
- Phase 1 of the Candidate selection process requires completion of a writing exercise within a required timeframe. Candidates are contacted by email.

KNOWLEDGE, SKILLS AND ABILITIES (KSAs)

- Knowledge off ALTCS Medical and Financial eligibility and MCS and MA-SP Federal and State rules, regulations, policies and procedures and of personnel rules, policies and procedures
- Knowledge of the tasks and functions performed by ALTCS supervisors, financial and medical eligibility staff, clerical staff and central office staff
- Knowledge of Quality Control (QC) and Quality Assurance (QA) process and how findings relate to the specific functions performed by staff
- Some knowledge of the functions of other divisions and administrations and how their work affects the operations of ALTCS
- Skill in establishing and maintaining effective working relationships with professional subordinates while evaluating their work and recommending changes

- Skill in organizational, prioritizing, scheduling, coordinating and implementing workload
- Strong management and leadership skills; data collection and analytical skills; Strong interpersonal skills to effectively manage staff and interact with program contractors, health plans and AHCCCS members
- Ability to interpret, analyze and apply current laws, rules, regulations and policies
- Ability to direct subordinates and determine work assignments
- Ability to communicate effectively, both orally and in writing

Selective Preference(s)

- Three years of professional experience related to health program in Aging, Developmental/Physical Disabilities or Mental Health, which include program planning or administration.
- A Master's Degree in Nursing, Social Work, Rehabilitation, Counseling, Education, Sociology, Psychology or closely related field may substitute for one year of the required experience.

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.

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Click the APPLY NOW button to submit your application.

For technical assistance, email click apply or call click apply.

- **Seniority level**

  Associate

- **Employment type**

  Full-time

- **Job function**

  Project ManagementInformation Technology

- **Industries**

  InsuranceGovernment AdministrationHospital & Health Care

Health Care Cost Containment hiring DIRECTOR OF HOUSING in Phoenix, AZ, US

SourceURL: https://www.linkedin.com/jobs/view/director-of-housing-at-health-care-cost-containment-1267475521

This position will remain open until filled

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Job Summary

The **Division of Health Care Management (DHCM)** is looking for a highly motivated individual to join our team as a Director of Housing. The Director of Housing will lead one of the most unique and innovative permanent supportive housing programs in the country. As a key role within the agency, the Housing Director will oversee a portfolio of over 3,200 units of permanent supportive housing throughout the State of Arizona and will work with a network of health plans and service providers. The Director of Housing will also be responsible for managing a $2 million dollar a year housing trust fund aimed at development and acquisition of affordable housing. Major duties and responsibilities include but are not limited to:

- Set direction, create linkages among programs and departments, lead housing staff within health plans and establish targets necessary to achieve the strategies and mission of the agency.
- Ensure program compliance with federal law, applicable state laws and AHCCCS related policy. Ensure proper monitoring of housing programs including utilization, average housing assistance payments, vacancy rates, and evictions/terminations.
- Develop and prepare annual budgets and spending plans for contractors that are allocated housing funds. Create and implement audit protocol for housing programs including HQS inspections, rent calculations, payment standards and adherence to fair housing principles. Assist with the development of new housing programs in accordance with agency plans, review and evaluate site selection criteria, comprehensive plans, housing market analyses, need studies and related reports.
- Serve on key committees and roles such as The Continuum of Care, Coordinated Entry sub-committees, Governor's Goal Council and other special projects as directed. Provide technical expertise to the Director of Medicaid, health plans, community partners and members as needed.
- Work with community partners to leverage the SMI Housing Trust Fund for development and acquisition of real estate.
- Recommend new policies; develop procedures and strategies for implementation. Review, analyze and control operational effectives and related work practices, develop and implement strategies for operational improvement and program advancement.
- Develop and maintain strategic partnerships with a variety of stakeholders to advance program objectives. Deliver presentations as directed to a variety of community stakeholders, government agencies and interested parties.

KNOWLEDGE, SKILLS AND ABILITIES (KSAs)

- Demonstrated knowledge of Federal and State housing programs for specialty populations: potential sources of funding to support implementation of the permanent supportive housing model.
- Demonstrated knowledge of Performance Management (PM) Model and continuous quality improvement (CQI) methods.
- Demonstrated knowledge of State and Federal laws, regulations, rules and practices for affordable housing and permanent supportive housing.
- Must possess excellent oral and written presentation and communication skills for diverse audiences
- Strong skills with computer programs such as Google email and calendar; Microsoft Word, Excel and Powerpoint
- Strong ability to present and engage with large groups of diverse stakeholders including members, providers, health plans and policymakers.

Selective Preference(s)

- Five-years of experience in public housing, housing choice voucher or homeless systems administration, or similar experience in residential, rental property management, or affordable housing and or homeless-centered service delivery systems, including four years of senior-level managerial experience.
- Master's Degree preferred

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.

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Click the APPLY NOW button to submit your application.

For technical assistance, email click apply or call click apply.

- ## Seniority level

  Director

- ## Employment type

  Full-time

- ## Job function

  Other

- ## Industries

  InsuranceGovernment AdministrationHospital & Health Care

HCA Healthcare hiring Medicaid Eligibility Advocate in Montgomery, AL, US

SourceURL: https://www.linkedin.com/jobs/view/medicaid-eligibility-advocate-at-hca-healthcare-1257479842

Description

SHIFT: Days (rotating weekends)

SCHEDULE: Full-time

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

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

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

">

Parallon is now seeking a Full-Time Medicaid Eligibility Advocate

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

What We Can Offer You

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

What You Will Do

- Responsible for conducting eligibility screenings, assessment of patient financial requirements, and counseling patients on insurance benefits and co-payments.
- Serve as a liaison between the patient, hospital, and governmental agencies; and you will be actively involved in all areas of case management.
- Screen and evaluate patients for existing insurance coverage, federal and state assistance programs, or hospital charity application.
- Re-verify benefits and obtains authorization and/or referral after treatment plan has been discussed, prior to initiation of treatment. Ensures appropriate signatures are obtained on all necessary forms.
- Obtain legal relevant medical evidence, physician statements and all other documentation required for eligibility determination, and complete and file applications.

- Initiate and maintain proper follow-up with the patient and government agency caseworkers to ensure timely processing and completion of all mandated applications and accompanying documentation.
- Document progress notes to the patient's file and the hospital computer system.
- Participate in ongoing, comprehensive training programs as required.
- Required to make field visits as necessary.

Qualifications

EXPERIENCE AND EDUCATION NEEDED:

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

About Us

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

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

#ParallonBCOM

Centers for Medicare & Medicaid Services hiring Supervisory Health Insurance Specialist. in Woodlawn, MD, US

SourceURL: https://www.linkedin.com/jobs/view/supervisory-health-insurance-specialist-at-centers-for-medicare-medicaid-services-1265312315

Summary

This position is located in the Centers for Medicare & Medicaid Services (CMS), Center for Medicaid and CHIP Services (CMCS), Disabled and Elderly Health Programs Group (DEPHG), Division of Benefits and Coverage (DBC).

As a Supervisory Health Insurance Specialist, GS-0107-14, you will share responsibility (with Division Director) for planning and coordinating the functions related to developing, interpreting, implementing, evaluating, and reviewing Medicaid benefits and coverage programs.

Responsibilities

    - Leading staff and serving as a role model for leadership, including coaching, mentoring, providing ongoing feedback, providing formal and informal learning opportunities; , as well as addressing staffing issues/problems when they arise.
    - Helping to lead the development, monitoring, enforcement, and the evaluation of regulations, policies, procedures, State Plan Amendments and other guidelines for States in the design and implementation of their Medicaid benefit and coverage program.
    - Participating and negotiating with high-ranking State and Federal officials on issues related to division work.
    - Facilitating, managing and building relationships with all internal and external Stakeholder groups including States, beneficiary groups, advocacy organizations, other federal agencies and senior policy makers.
- Travel Required
-
- Not required
-
- Supervisory status
-
- Yes
-
- Promotion Potential
-

  14
- Job family (Series)
- Requirements

  Conditions of Employment
    - You must be a U.S. Citizen or National to apply for this position.
    - You will be subject to a background and suitability investigation.
    - Time-in-Grade restrictions apply.
- **Qualifications**
-
- **ALL QUALIFICATION REQUIREMENTS MUST BE MET WITHIN 30 DAYS OF THE CLOSING DATE OF THIS ANNOUNCEMENT.**
-

  In order to qualify for the GS-14 , you must meet the following: You must demonstrate in your resume at least one year (52 weeks) of qualifying specialized experience equivalent to the GS-13 grade level in the Federal government, obtained in either the private or public sector, to include:
- Developing and/or reviewing policies related to Medicaid benefits and coverage design;
- Leading and/or providing technical direction to staff engaged in such work, including administrative operations of the programs; AND
- Preparing technical and non-technical documents such as briefing documents, analytical reports, standard operating procedures,
  guidelines, issue papers, administrative and management reports
  Experience refers to paid and unpaid experience, including volunteer work done through National Service programs (e.g., Peace Corps, AmeriCorps) and other organizations (e.g., professional; philanthropic; religious; spiritual; community, student, social). Volunteer work helps build critical competencies, knowledge, and skills and can provide valuable training and experience that translates directly to paid employment. You will receive credit for all qualifying experience, including volunteer experience.
  Time-in-Grade: To be eligible, current Federal employees must have served at least 52 weeks (one year) at the next lower grade level from the position/grade level(s) to which they are applying.
  Click The Following Link To View The Occupational Questionnaire
  Education
  This job does not have an education qualification requirement.
  Additional information

Bargaining Unit Position: No**Tour of Duty:** Flexible**Recruitment/Relocation Incentive:** Not Authorized**Financial Disclosure:** OGE-450

The Interagency Career Transition Assistance Plan (ICTAP) and Career Transition Assistance Plan (CTAP) provide eligible displaced federal employees with selection priority over other candidates for competitive service vacancies. To be qualified you must submit the required documentation and be rated well-qualified for this vacancy.

Additional Forms REQUIRED Prior To Appointment

- **Optional Form 306, Declaration of Federal Employment and the Background/Suitability Investigation** - A background and suitability investigation will be required for all selectees. Appointment will be subject to the successful completion of the investigation and favorable adjudication. Failure to successfully meet these requirements may be grounds for appropriate personnel action. In addition, if hired, a reinvestigation or supplemental investigation may be required at a later time. If selected, the Optional Form 306 will be required prior to final job offer.
- **Form I-9, Employment Verification and the Electronic Eligibility Verification Program** - CMS participates in the Electronic Employment Eligibility Verification Program (E-Verify). E-Verify helps employers determine employment eligibility of new hires and the validity of their Social Security numbers. If selected, the Form I-9 will be required at the time of in-processing.
- **Standard Form 61, Appointment Affidavits** - If selected, the Standard Form 61 will be required at the time of in-processing.

Additional selections may be made from this announcement for similar positions within CMS in the same geographical location. For Central Office vacancies, the "same geographical location" includes Baltimore, Maryland; Bethesda, Maryland; and Washington, D.C.

If you are unable to apply online or need to fax a document you do not have in electronic form, view the following link for information regarding an

How You Will Be Evaluated

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

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

- Building Coalitions/Communications
- Business Acumen
- Health Insurance
- Leading People
- Managing Change
- Results Driven

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.).** Current CMS employees are REQUIRED to submit a copy of their most recent Notification of Personnel Action (SF-50) at the time of application. Additional documents may also be required to be considered for this vacancy announcement.
  PLEASE NOTE: A complete application package includes the online application, resume, and CMS required documents. Please carefully review the full job announcement to include the "Required Documents" and "How to Apply" sections. Failure to submit the online application, resume and CMS required documents, will result in you not being considered for employment.
- Benefits

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

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

  Your complete application package, as described in the "Required Documents" section, must be received by 11:59 PM ET on 05/15/2019 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 Tanisia.whitlock@cms.hhs.gov. The decision to grant reasonable accommodation will be made on a case-by-case basis.
-
- **Commissioned Corps Officers** (including Commissioned Corps applicants that are professionally boarded) who are interested in applying for this position must send their professional resume (not PHS Curriculum Vitae) and cover letter to
-
- CMS employees who are currently appointed under Schedule A authority and are interested in applying for this position must submit their resume, Schedule A documentation, transcripts (if positive education required or qualifying through education substitution), and cover letter (optional) to Tanisia.whitlock@cms.hhs.gov. You MUST include the Job Announcement Number in the subject line of the email to receive consideration for the position. For additional information regarding Schedule A authority
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- Agency contact information
-
- Tanisia Whitlock
-
- Phone
-
- Email
-
- 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. Your application will be evaluated to determine your eligibility and qualifications for the position. After the evaluation is complete, you will receive another email notification regarding the status of your application.
-
  Within 30 business days of the closing date,05/15/2019, you may check your status online by logging into your USAJOBS account (
- Fair & Transparent

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

  Equal Employment Opportunity Policy

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

  Reasonable Accommodation Policy

  Federal agencies must provide reasonable accommodation to applicants with disabilities where appropriate. Applicants requiring reasonable accommodation for any part of the

application process should follow the instructions in the job opportunity announcement. For any part of the remaining hiring process, applicants should contact the hiring agency directly. Determinations on requests for reasonable accommodation will be made on a case-by-case basis.

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

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

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

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

  Legal and regulatory guidance

This job originated on

- **Seniority level**

  Not Applicable

- **Employment type**

  Full-time

- **Job function**

  Health Care Provider

- **Industries**

  Government AdministrationProgram Development

State of Louisiana hiring Medicaid Program Manager 1--b (health Plan Provider Network Compliance Manager) in Baton Rouge, LA, US

SourceURL: https://www.linkedin.com/jobs/view/medicaid-program-manager-1-b-health-plan-provider-network-compliance-manager-at-state-of-louisiana-1265129547

Supplemental Information
Job Number: MVA/SAG/1079
This position is located within the Louisiana Department of Health l Medical Vendor Administration l BHSF / Program Ops and Compliance l EBR Parish.
Cost Center: 0305-7202
Position Number(s): 171572
This vacancy is being announced as a Classified position and may be filled either as a Probationary Appointment, Job Appointment or Promotional Appointment.
* Resumes will not be accepted in lieu of job experience on application.*

Experience Preferred

Experience with health plan provider access and availability requirements as determined by the organization's policies, contract,and state and federal regulations.
Experience with developing and maintaining ongoing reporting on provider contract status.
Experience with the provider contracting process.
Experience with working in a team environment with a spirit of cooperation.
Experience with approaching tasks in an analytical manner, with attention to detail and the capacity to achieve targeted goals in a timely manner while working independently.
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 our Baton Rouge Information and Testing Office 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 our Baton Rouge Information and Testing Office 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 www.jobs.la.gov).

For Further Information About This Vacancy Contact

Sanaretha Gray @ Sanaretha.Gray@la.gov

LDH/HUMAN RESOURCES
P.O. BOX 4818 BATON ROUGE, LA 70821
225 342-6477
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 four years of professional experience in administrative services, economics, public health, public relations, statistical analysis, social services, or health services.

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 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 experience.
A Juris Doctorate will substitute for one year of the required experience.
Graduate training with less than a Ph.D. will substitute for a maximum of one year of the required experience.
A Ph.D. in the above fields will substitute for two years of the required experience.
Advanced degrees will substitute for a maximum of two years of the required 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 administer small and less complex statewide Medicaid program(s).

Level Of Work

Manager.

Supervision Received

Broad from a higher-level manager/administrator.

Supervision Exercised

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

Job Distinctions

Differs from Medicaid Program Monitor by responsibility for administering small and less complex statewide program(s) and supervision exercised.
Differs from Medicaid Program Manager 1-A by the presence of supervisory responsibility.
Differs from Medicaid Program Manager 2 by the absence of responsibility for administering medium size or moderately complex statewide program(s) and supervision exercised.
Examples of Work
Supervises the auditing of eligibility enrollment of all Medicaid programs statewide.
Reviews work of eligibility review staff for quality assurance.
Plans, coordinates, and controls a small or less complex statewide program.
Plans, develops, implements and monitors comprehensive Medicaid program policies.
Conducts and directs studies/special projects pertaining to the programs assigned.
Analyzes the impact of federal, state, and local legislation; advises agency officials; prepares position statements; presents testimony at hearings; writes legislation.
Reviews and analyzes complex data and system reports to ensure compliance with program regulations.
Administers the day-to-day operational functions of the Medicaid fee for service programs.
Assures that program policy and procedures are properly applies in accordance with federal and state laws and regulations.
Develops and writes agency rules and regulations governing the administration of all supervised Medicaid programs and submit them for publishing in the official state publication in accordance with the requirements of the Administrative Procedures Act.
Implements Medicaid regulations directing provider participation standards and recipient benefits. Analyzes multi-mullion dollar Medicaid claim data and project the fiscal impact for budget forecasting.
Identifies, verifies and analyzes the various revenue sources for the program(s). Determines and/or confirms match requirements. Monitors availability of revenue sources and promptly identifies existing or potential financing problems.

- **Seniority level**

  Associate

- **Employment type**

  Contract

- **Job function**

  Health Care Provider

- **Industries**

Higher EducationGovernment AdministrationFinancial Services

Centers for Medicare & Medicaid Services hiring Health Insurance Specialist. in Washington, D.C., US

SourceURL: https://www.linkedin.com/jobs/view/health-insurance-specialist-at-centers-for-medicare-medicaid-services-1265312710

- Duties

  Summary

  This position is located in the Department of Health & Human Services (HHS), Centers for Medicare & Medicaid Services (CMS), Office of Legislation (OL), Audit Management Group (AMG).

  As a Health Insurance Specialist, GS-0107-13, you will be responsible for coordinating GAO and OIG audits relating to Medicare, Medicaid, CHIP, and private health insurance issues. You will serve as a technical resource for CMS staff in drafting and clearing the CMS response to audit reports.

  Responsibilities
    - Write, edit, and assist in the preparation of background papers, fact sheets, briefing materials, and presentations on Medicare, Medicaid, CHIP, and private health insurance issues for GAO and OIG reports.
    - Write or edit written responses related to GAO and OIG audits on the Medicare, Medicaid, CHIP, and private health insurance programs.
    - Coordinate with CMS components and OL colleagues to ensure that CMS responses and briefing materials address specific interests highlighted by the GAO and OIG.
    - Research statutes, regulations, manual issuances, journal articles, published reports, prior congressional hearing transcripts, prior testimony, correspondence, and other reference materials to identify data and policy positions.
- Travel Required
-
- Not required
-
- Supervisory status
-
- No
-
- Promotion Potential
-

  13
- Job family (Series)
- Requirements

  Conditions of Employment
    - You must be a U.S. Citizen or National to apply for this position.

    - You will be subject to a background and suitability investigation.
    - Time-in-Grade restrictions apply.
- **Qualifications**
-
- **ALL QUALIFICATION REQUIREMENTS MUST BE MET WITHIN 30 DAYS OF THE CLOSING DATE OF THIS ANNOUNCEMENT.**
-
- **In order to qualify for the GS-13**, 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-12 grade level in the Federal government, obtained in either the private or public sector, to include: 1) reviewing emerging issues (e.g. press reports, new legislation, congressional hearings, or correspondence) relating to the Medicare, Medicaid, Children's Health Insurance Program (CHIP), or private health insurance programs; 2) producing written documents related to Office of Inspector General (OIG) or Government Accountability Office (GAO) reports on Medicare, Medicaid, CHIP, or private health insurance programs; and 3) serving as a contact for Congressional staff or auditors regarding the Medicare, Medicaid, CHIP or private health insurance programs.
-
- 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.
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- **Time-in-Grade:** To be eligible, current Federal employees must have served at least 52 weeks (one year) at the next lower grade level from the position/grade level(s) to which they are applying.
-
- **Click The Following Link To View The Occupational Questionnaire**
-
- Education
-
- This job does not have an education qualification requirement.
-
- Additional information
-
- **Bargaining Unit Position:** Yes - 2268
- **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.
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- **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.
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- How You Will Be Evaluated
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-
  Your qualifications will be evaluated on the following competencies (knowledge, skills, abilities and other characteristics):
    - Analysis
    - Health Insurance
    - Oral Communication
    - Written Communication
- Background checks and security clearance
-
- Security clearance
-
- Drug test required
-
  No
- Required Documents

  <u>The Following Documents Are REQUIRED</u>
- **Resume showing relevant experience; cover letter optional**. Your resume must indicate your citizenship and if you are registered for Selective Service if you are a male born after 12/31/59. Your resume must also list your work experience and education (if applicable) including the start and end dates (mm/dd/yy) of each employment along with the number of hours worked per week. For work in the Federal service, you must include the series and grade level for the position(s). Your resume will be used to validate your responses to the assessment tool(s). For resume and application tips visit:
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- 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.
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  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)
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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 Heidi.vause@cms.hhs.gov. The decision to grant reasonable accommodation will be made on a case-by-case basis.
-
- **Commissioned Corps Officers** (including Commissioned Corps applicants that are professionally boarded) who are interested in applying for this position must send their

professional resume (not PHS Curriculum Vitae) and cover letter to

- CMS employees who are currently appointed under Schedule A authority and are interested in applying for this position must submit their resume, Schedule A documentation, transcripts (if positive education required or qualifying through education substitution), and cover letter (optional) to Heidi.vause@cms.hhs.gov. You MUST include the Job Announcement Number in the subject line of the email to receive consideration for the position. For additional information regarding Schedule A authority
- Agency contact information
- Heidi Vause
- Phone
- Email
- Address
- Office of Legislation
- 7500 Security Blvd
- Woodlawn, MD 21244
- US
- Next steps
- Once your online application is submitted, you will receive a confirmation notification by email. Your application will be evaluated to determine your eligibility and qualifications for the position. After the evaluation is complete, you will receive another email notification regarding the status of your application.
- Within 30 business days of the closing date,05/16/2019, you may check your status online by logging into your USAJOBS account (
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- An applicant with a disability needs an accommodation to have an equal opportunity to apply for a job.
- An employee with a disability needs an accommodation to perform the essential job duties or to gain access to the workplace.
- An employee with a disability needs an accommodation to receive equal access to benefits, such as details, training, and office-sponsored events.

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

  Legal and regulatory guidance

This job originated on

- **Seniority level**

  Not Applicable

- **Employment type**

  Full-time

- **Job function**

  Health Care Provider

- **Industries**

  Government AdministrationProgram Development

Medicaid Specialist I

SourceURL: https://www.governmentjobs.com/jobs/2442450-0/medicaid-specialist-i?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Characteristics of Work

This is investigative work involving the interpretation of policy to determine Medicaid eligibility for families and children and aged, blind, and disabled individuals. The incumbent makes the initial and continuing determinations of eligibility for Medicaid recipients who live in private and institutional settings. Limited supervision is received from administrative supervisors who oversee a regional office or Central Enrollment Office.

Examples of Work

Examples of work performed in this classification include, but are not limited to, the following:

Assumes responsibility for a Medicaid eligibility determination caseload for a designated territory within a region.

Investigates and verifies accuracy of information provided by recipients under the Medicaid programs to determine compliance with State and Federal laws, rules, and regulations.

Determines an applicant's eligibility for institutional care based on State and Federal guidelines and verifies the accuracy of information listed on the applicants' applications.

Maintains effective public relations with medical facilities and federal, state, county, and city agencies within assigned territory.

Verifies accuracy of information listed on applicants' applications including income, bank accounts, and any other assets.

Makes determination of an applicant's eligibility based upon established criteria.

Visits contact centers and medical facilities; assists other regional offices on an as-needed basis.

Performs related or similar duties as required or assigned.

Minimum Qualifications

These minimum qualifications have been agreed upon by Subject Matter Experts (SMEs) in this job class and are based upon a job analysis and the essential functions. However, if a candidate believes he/she is qualified for the job although he/she does not have the minimum qualifications set forth below, he/she may request special consideration through substitution of related education and experience, demonstrating the ability to perform the essential functions of the position. Any request to substitute related education or experience for minimum qualifications must be addressed to the Mississippi State Personnel Board in writing, identifying the related education and experience which demonstrates the candidate's ability to perform all essential functions of the position.

EXPERIENCE/EDUCATIONAL REQUIREMENTS:

Education:
A Bachelor's Degree from an accredited four-year college or university.

OR

Education:
An Associate's Degree or completion of sixty (60) semester hours from an accredited college or university;

AND

Experience:
Two (2) years of experience related to the described duties.

Substitution Statement:
Above an Associate's Degree or completion of sixty semester hours from an accredited college or university, related education and related experience may be substituted on an equal basis.

Essential Functions

Additional essential functions may be identified and included by the hiring agency. The essential functions include, but are not limited to, the following:

1. Maintains caseload for Medicaid eligibility.

2. Maintains good public relations and customer service.

3. Collects eligibility data information.

4. Visits Medicaid contact centers and/or long-term care facilities.