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Medicaid Jobs Hunter

In this packet....

University of Utah Health Care Psychiatry Medical Director - University of Utah Health Plans Job in Murray, UT

SourceURL: https://www.glassdoor.com/job-listing/psychiatry-medical-director-university-of-utah-health-plans-university-of-utah-health-care-JV_IC1157881_KO0,59_KE60,90.htm?

jl=3259347883

Psychiatry Medical Director - University of Utah Health Plans

University of Utah Health Plans is seeking a new Psychiatry Medical Director to oversee the Behavioral Health/Addictive Medicine responsibilities for all The University of Utah Health Plans programs membership.

This position combines clinical expertise with financial stewardship to support U of U Health Plans behavioral health programs. It supports the organization's goals and mission by leading the functions of the General Psychiatry and Addiction Medicine within Health Plans.

Department Overview: This position reports directly to the Chief Medical Officer- University of Utah Health Plans University of Utah Health Plans covers approximately 200,000 members in Utah and the Mountain West Region. The plan offers services in Commercial, Individual Exchange, and Medicaid Markets.

Corporate Overview: University of Utah Healthcare is an integrated academic healthcare system with four hospitals including a level 1 trauma center, twelve community health centers, over 1,600 providers, and a health plan serving over 200,000 members.

University Healthcare is nationally ranked and recognized for our academic research, quality standards and overall patient experience.

In addition to our clinical delivery system, we have a School of Medicine, School of Dentistry, College of Nursing, College of Pharmacy, and College of Health providing education and training for over 1,250 providers annually. We have over 2 million patient visits annually and research grants exceeding $350 million.

This position has no responsibility for providing care to patients.

It's been a winning few years…

University of Utah Health was ranked 35th in the nation as one of America's Best Large Employers by Forbes in 2018 and 2019, and is the only health care provider from the state of Utah to receive the designation.

University of Utah Health credits its employees for its national ranking as a Top 10 Academic Medical Center for quality and safety for NINE consecutive years.

In addition to its placement on the Top 10 list, U of U Health placed fifth for Excellence in Ambulatory Care! This is the fourth year in a row the U has been ranked in the Top 5 for delivering high-quality, patient-centered, efficient and effective outpatient care.

The University of Utah Hospital also received the award for the Best Hospital in Utah in 2018!

Not surprisingly, health care organizations with higher levels of staff engagement also have higher patient satisfaction scores, better staff retention, and a stronger culture of safety. It's a great place to work and live, and the nation is taking note!

As a patient-focused organization, University of Utah Health exists to enhance the health and well-being of people through patient care, research and education. Success in this mission requires a

culture of collaboration, excellence, leadership, and respect. University of Utah Health seeks staff that are committed to the values of compassion, collaboration, innovation, responsibility, diversity, integrity, quality and trust that are integral to our mission. EO/AA

Accountability

- Work with the Chief Medical Officer and UUHP leadership to help develop best practice and appropriate strategy to provide services related to behavioral health and addiction medicine.
- Combine clinical expertise and financial stewardship to grow and support U of U Health Plans behavioral health programs.
- Collaborate with business owners to expand Plan's behavioral health lines of business including commercial, Medicaid, and Medicare.
- Oversee all Utilization Management for behavioral health services.
- Ensure services are built and maintained to meet regulatory standards as well as expectations of clients.

Collaboration

- Facilitate cooperative and collaborative community and institutional relationships, with internal and external customers.
- Contribute as a key member of the leadership team and other committees addressing various strategic outcomes and initiatives and work activities across U of U Health Plan.

Communication

- Conduct inter-rater behavioral health meetings with Utilization Management/Case Management teams to assure compliance in interpreting review guidelines and provide education for ongoing consistency in the review processes related to substance use and/or behavioral health services
- Interface with clients to update on trends, risks, opportunities, and challenges related to mental health services.
- Proactively engage with all internal and external business partners to achieve plan goals and organization business objectives.

Technical Development

- Understand inter-rater reliability processes for the team of nurses and providers to assure consistency in decision making
- Develop and maintain strategies consistent with evolving national programs, methodologies and technologies.
- Collect and analyze data related to quality or performance improvement for UUHP behavioral health services.

Financial Management

- Assist in developing, monitoring and achieving budget goals for the mental health product line.
- Manage labor and non-labor expenses to budget or flex budget.

Quality/EPE

- Work cross-functionally with Clinical Care Services, Network Management, Member Services, Finance, Government Programs, and other leadership to meet and exceed quality and cost.
- Work with Network Team to assess adequacy and make recommendations to improve mental health services.
- Assist the Care Management team in making judgements regarding appropriateness of care, length of stay and medical necessity.

- Promote physician/provider compliance with, recognized national guidelines, clinical pathways and protocols.
- Analyze the department's performance and implement measures designed to improve performance.
- Responsible for upholding PROMISE standards in all internal and external interactions.

Performance/Human Resource Management

- Provide staff feedback on performance, including on-time appraisals and coaching.
- Recognize staff when appropriate.

Relationships and Engagement

- Form positive relationships with staff, physicians, peers, and senior leadership to support the mission, vision, values and performance standards of the organization.
- Actively engage staff with updates and news as well as involving staff in decisions and work teams.

Knowledge / Skills / Abilities

- Ability to perform the KPIs of the position, as outlined above.
- Demonstrated verbal and written communication skills.
- Ability to communicate and collaborate with internal leaders and staff, as well as external stakeholders (delivery system and contracted providers) to achieve goals.
- Knowledge of regulatory and standards of care related to addiction/behavioral health.
- Demonstrated appreciation of cultural diversity and sensitivity towards target population.
- Demonstrated understanding of managed health care delivery systems and operations and accreditation requirements.
- Ability to maintain knowledge of accreditation standards and contractual obligations for performance and apply continuous quality improvement principles.
- Demonstrated superior computer and data analysis skills including Microsoft Access, Microsoft Excel, and other financial & statistical software packages.
- Demonstrated strong project management skills.
- Demonstrated leadership skills including the ability to guide and manage change, and to accept responsibility for process improvement.
- Demonstrated strength in team building, interpersonal skills, and the ability to initiate and maintain cross-department initiatives.
- Demonstrated ability to deal with conflicts in a proactive manner and to reach resolution in a timely manner.
- Ability to form positive relationships with staff, peers, and senior leadership to support the mission, vision, values, and performance standards of the organization.

QualificationsRequired

- Current licensure to practice medicine in the State of Utah. (M.D. or D.O.)
- Board Certification in Psychiatry.
- Two years of full-time clinical practice experience.

Preferred

- Experience with population health, case management, or managed care.
- Experience in program development.

Working Conditions and Physical Demands

Employee must be able to meet the following requirements with or without an accommodation.

- This is a sedentary position that may exert up to 10 pounds and may lift, carry, push, pull or otherwise move objects. This position involves sitting most of the time and is not exposed to adverse environmental conditions.

Listening, Manual Dexterity, Speaking

Fidelis Care hiring Actuary (Medicaid) in Rego Park, NY, US

SourceURL: https://www.linkedin.com/jobs/view/actuary-medicaid-at-fidelis-care-1305962183

Professional Position Purpose Conduct analysis, pricing and risk assessment to estimate financial outcomes.

- Apply knowledge of mathematics, probability, statistics, principles of finance and business to calculate financial outcomes
- Develop probability tables based on analysis of statistical data and other pertinent information
- Review insurance plans and calculate required premium rates
- Ensure cash reserves and liabilities enable payment of future benefits
- Determines equitable basis for distributing money for insurance benefits
- Participate in merger and acquisition analysis
  Education/Experience Bachelor's degree or in related field or equivalent experience. 7+ years of actuarial experience.

  License/Certification Associate of the Society of Actuaries (ASA) (or equivalent international certification); Member of American Academy of Actuaries (or equivalent international membership)

  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**

  ResearchAnalystAccounting/Auditing

- **Industries**

  Hospital & Health CareInsurance

Sr Director-Medicaid Plan CFO at Aetna in

Princeton

SourceURL: https://www.aetnacareers.com/job/princeton/sr-director-medicaid-plan-cfo/41/12160161

Primary Location: Princeton, New Jersey
Additional Locations: NJ-Princeton Apply
Description:
New Jersey Plan Medicaid CFO, key leadership role in New Jersey Medicaid Plan. Direct interaction with New Jersey leadership team as well as key contact with the state agencies. Responsible for financial reporting, budget and forecasting as well as monthly results. Key strategic leader for the local Plan as well as the Medicaid segment. The right person can make a significant contribution to the success of the Plan.

Senior Director, Finance (Medicaid Plan CFO) located in our New Jersey office is responsible for leading a team which manages all the finance functions for Aetnas Medicaid Business in New Jersey. This position is a key member of the local management team and is responsible for local, regional as well as state contract financial reporting, analysis and compliance

Fundamental Components:
-Oversight of all financial activities for a stand alone business unit Partners with business unit leader to execute short and long-range strategic plan.
-Partner with business unit management to analyze and support full P&L responsibility.
-Support the coordination and development of business unit financial plans and forecasts.
-Drive month end close process and ensure timely local and segment reporting.
-Drive the dissemination and collection of input/output data, critical assumption and management reporting requirements -Coordinate development and monitor implementation of major business unit action plans to seize competitive opportunities and/or respond to performance shortfalls/plan variances.
-Identify emerging product / market trend vulnerabilities and opportunities through analysis; review all assigned markets, develop and implement action plans.
-Interact with state agency and maintain timeliness of state reporting.

Primary Focus:
*Accountable for day-day management of financial operations as well as monitoring/ reporting the related business goals and objectives.
*Key member and advisor for local management team leaders as well as Regionals and Segment leadership
*Ensure that local business operates effectively, with sound financial analysis, financial reporting as well as appropriate financial and operating controls.
*Direct the monthly financial close and preparation, review and reconciliation of financial statements and communicate of related information to local as well as segment management.
*Solid accounting, financial forecasting/budgeting, financial discipline and knowledge of medical economics.
*Provide analysis and support for developing ideas, programs and provide assistance and guidance with local SAI process.
*Ongoing interaction with actuary, tax, statutory and other Aetna departments.

Oversight would include:
*Lead and developing a team of 3 FTEs currently overseeing financials across separate lines of business.

*Interaction with senior finance and business executives to provide periodic updates and guidance.
*Provide continuous feedback on ability to achieve financial commitments and work with businesses to identify and execute local as well as segment goals.
*Communicate and present monthly financial reviews, quarterly forecast updates and annual operating planning/ budgeting as well as financial planning and analysis processes

Background Experience:
The optimal candidate will have a solid accounting, financial forecasting/budgeting, financial discipline and knowledge of medical economics. The Senior Director, Finance will be responsible to implement various management processes for driving best practices within functions of responsibility leveraging experience within the broader Medicaid finance business unit.

-Project Management experience required;
-10-15 years significant/pertinent financial planning and analysis experience; knowledge of healthcare, managed care, insurance or financial services;
-Prior P&L responsibility required.
-Bachelor's Degree in Finance, Accounting, Actuarial Science or similar disciplines required.
-Advanced degree in Business and/or FSA/CPA preferred.

Additional Job Information:
Partner with local management team to help achieve financial and operating goals.

Required Skills:
Finance - Delivering Profit and Performance, Leadership - Developing and Executing Strategy, Leadership - Driving a Culture of Compliance

Desired Skills:
Finance - Managing Aetnas Risk, Leadership - Collaborating for Results, Leadership - Creating Accountability

Functional Skills:
Finance - Financial analysis, Finance - Financial Budgeting, Finance - Financial Forecasting, Finance - Financial reporting and analysis - internal control

Potential Telework Position:
No

Percent of Travel Required:
0 - 10%

EEO Statement:
Aetna is an Equal Opportunity, Affirmative Action Employer

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

Candidate Privacy Information:
Aetna takes our candidate's data privacy seriously. At no time will any Aetna recruiter or employee request any financial or personal information (Social Security Number, Credit card information for direct deposit, etc.) from you via e-mail. Any requests for information will be discussed prior and will be conducted through a secure website provided by the recruiter. Should you be asked for such information, please notify us immediately.

Click To Review Our Benefits (PDF)

Apply

Syrainfotek hiring Business Analyst with Medicare/Medicaid with Syrainfotek in Norfolk, VA, US

SourceURL: https://www.linkedin.com/jobs/view/business-analyst-with-medicare-medicaid-with-syrainfotek-at-syrainfotek-1317045216

The position listed below is not with Rapid Interviews but with Syrainfotek Our goal is to connect you with supportive resources in order to attain your dream career. We work directly with hundreds of publishers to connect you with the right resources to fit your needs. You may also want to visit our News & Advice page to stay up to date with other resources that can help you find what you are looking for Job #1: Hi Business Analyst with Medicare/Medicaid Location: Norfolk, VA Duration: 12 Months Please share me resume at Preferred Location: The preferred location is at our Virginia Beach office, if you are within 35 miles of the office, you will be required to work in office The option to work remotely will also be available This opportunity is within the Cost Containment Division (also known as Claims Recovery) within the Program Integrity Business Unit. We ensure the financial systems integrity is accurate and processes are streamlined. This division focuses on overpayment recoveries and claims cost corrections. This ensures the best health care practices in the industry. The Business Analyst III translates complex business needs into application software requirements. The BA III should also be responsible for writing business process specifications including Visio Diagrams, and process instructions. We are looking for motivated, creative, solutions experts who can help take health care to the next level. BA III is responsible for serving as the liaison between the business and IT in translating complex business needs into application software. This can include supporting training, and auditing processes. Develops project plans and identifies and coordinates resources, involving those outside the unit. The ability to develop or modify complex business requirements to satisfy business needs in operationally efficient manner. Acts as subject matter expert to provide business and technical expertise in requirements solicitation, system analysis, trouble shooting and documentation of business applications/systems. Collaborate with business owners to analyze current operational procedures, trends and identify problems. May provide direction and guidance to team members and serve as an expert for the team. Experience maintaining business and system requirements of multi-functional complex system Conducts business analysis and recommends technical alternative solutions to management as to course of action that best meets the department''s goals. Query development and data analysis skills strongly desired (using any database technology) The ability to initiate or assist with testing of changes as it relates to projects assigned. Act as a business liaison between system IT and Claims Recovery Department Strong skills in building and maintaining successful relationships with key leaders across the department and organization to insure that projects are properly supported and successfully delivered. May be responsible for monitoring and reporting to management on the status of departmental projects: Anticipates and identifies issues that could inhibit achieving the project goals and objectives, and implementing corrective actions and mitigation strategies. Provides guidance and training to staff on process, procedures and issue resolution. Understanding of claims overpayment recovery processes a plus Ability to convert contract language into business requirements Provides oversight and resolves complex issues, resolving problems, and providing timely follow-up on identified issues. Ability to participate on project teams and add significant and measurable technical input to the projects Provide regular feedback to management on project status Performs other duties as assigned. Requirements Requires a BS/BA degree; or any combination of education and experienced, which would

provide an equivalent background. 5-7 years of business analysis experience that includes knowledge of systems capabilities and business operations including ability to understand detailed business processes and enabling software. The ability to identify any process, technology, or organizational role changes that would pose risks on any assigned projects or initiatives relative to the department and offer mitigation and contingency plans. Strong analytical skills, high attention to detail, and proven ability to be an innovative problem solver. Organize and present ideas in a convincing and compelling manner. Persuade and influence others with effective verbal and written communication. Strong communication skills both written and verbal to represent the department in various meetings with various levels of management. Strong organizational skills to be able to manage supporting multiple projects at one time. Experience in the following systems is a plus: Facets, Financial Systems
Associated topics: analyse, analysis, analyze, bi, government, market, refine, refinement, regulation, valuation analyst

Meridian hiring Fraud, Waste and Abuse Investigator in Detroit, MI, US

SourceURL: https://www.linkedin.com/jobs/view/fraud-waste-and-abuse-investigator-at-meridian-1305415658

Overview

Who we are:

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

- Participate in the detection, investigation and ongoing monitoring of member and/or provider Fraud, Waste and Abuse through random audits, data analysis, medical record review and onsite and desk audits
- Provide recommended action based on investigative summary
- Proactively apply knowledge of current FWA Schemes, coding guidelines and medical policies to identify areas of risk for Fraud, Waste or Abuse
- Prioritize leads from external sources
- Stay current on published fraud cases
- Interview members and/or providers regarding the Fraud, Waste and Abuse in question
- Appropriately utilize the database to track and trend provider and member inquiries, concerns, complaints, and appeals as they relate to Fraud, Waste and Abuse and maintain complete case files
- Package Fraud, Waste and Abuse referrals to appropriate law enforcement and/or regulatory agencies

- Develop and administer provider education programs focusing on Fraud, Waste and Abuse best practices
- Develop internal fraud awareness training programs and consult Fraud, Waste and Abuse policies and procedures
- Participate in appropriate State Medicaid/Medicare task force meetings
- Assist in auditing and investigating EOB claims that are referred for fraud, waste and abuse for each state MHP is operating in and report the results to the Compliance Officer and the appropriate states FWA committee
- Review ER and Pharmacy history reports on members for possible abuse/non compliance
- Perform other duties as assigned

Qualifications

What you can bring to Meridian:

- Bachelor's degree is required
- Master's degree is preferred
- Strong interest in Medicare and Medicaid Fraud, Waste and Abuse investigation
- Other certifications a plus: Certified Coding Specialist (CCS), Certified Fraud Specialist (CFS), Accredited Healthcare Fraud Investigator (AHFI) and Certified Fraud Examiner (CFE)
- Minimum of 2 years' experience working on fraud Investigations or 2 years' experience analyzing, adjudicating, or processing healthcare claims required
- Experience investigating Medicaid and Medicare Fraud, Waste and Abuse a plus
- Computer proficiency in a Windows environment, including MS Office Suite
- Healthcare claims adjudication experience helpful
- Knowledge of Managed Care and the Medicaid and Medicare program is required
- Knowledge of National Committee for Quality Assurance (NCQA), URAC or general accreditation standards
- Working knowledge of Medicaid and Medicare a must
- Analytical and problem solving skills
- Strong written and verbal communication skills
- Strong listening and observation skills
- Proven ability to effectively handle cases of fraud and abuse in a discreet, confidential, and professional manner
- Attention to detail and high level of accuracy
- Works independently; collaborates well with peers and customers
- Demonstrated organizational and prioritization skills with ability to manage multiple priorities effectively

What Meridian Can Offer You

- Our healthcare benefits include a variety of plans that are effective on the first day of employment for our new full-time team members.
- Opportunity to work with the industry's leading technologies and participate in unique projects, demonstrations, conferences, and exclusive learning opportunities.
- Meridian offers 401k matching that is above the national average.
- Full-time Meridian employees are eligible for tuition reimbursement towards Bachelor's or Master's degrees.
- Meridian was named Detroit's #1 Fastest Growing Company by Crain's Magazine, so it is a great time to get involved with Meridian.

Equal Opportunity Employer

#MSTR

Shriners Hospitals for Children hiring Health

Plan Liaison in Tampa, FL, US

SourceURL: https://www.linkedin.com/jobs/view/health-plan-liaison-at-shriners-hospitals-for-children-1316291916

Job Description

As part of the Shriners Hospitals for Children (SHC) Department of Medical Affairs, the Health Plan Liaison is responsible for deployment of commercial and Medicaid managed care health plan requirements which Shriners Hospitals for Children sites participate with. The Health Plan Liaison will provide resources to ensure contract effectuation and continued compliance with payor guidelines; supports contracting efforts by determining enrollment needs and processes for dissemination to enrollment team; and acts as an interface with hospitals, Headquarters departments and insurance payors to support revenue goals.

The Health Plan Liaison continuously exemplifies the mission, vision, values and customer service philosophy of Shriners Hospitals for Children in job performance and in service to other persons outside of and throughout the organization.

Position Responsibilities

- Coordinates with Network Management to support payor contract deployment, timely enrollment activities, and dissemination of payor specific guidelines:
- Works in parallel to Network Management contracting efforts to ensure provider credentialing is initiated and completed timely.
- Establishes relationship with payors to obtain enrollment process, and continues working with health plan on ways to streamline provider onboarding/offboarding during the length of the contractual relationship.
- Escalates issues as needed to appropriate stakeholders at SHC and the payor to promote prompt resolution, and timely reimbursements.
- Subscribes to payor newsletter and updates. Disseminates updated payor guidelines and requirements to appropriate SHC departments and SHC sites.
- Supports provider enrollment activities through guidance to Provider Enrollment Specialists on Commercial and Medicaid Managed Care enrollment processes for professional billing, and to meet ORP requirements for telehealth services
- Coordinates with various departments and functions to maximize revenue for all SHC sites:
- Facilitates regular reporting to hospitals and headquarters leadership
- Coordinates with hospitals and Patient Financial Services to determining ROI on enrollments and prioritization to support billing, as well as Telehealth activities.
- Participates in Business Planning and Network Management Administrator calls, to provide updates, obtain information, address issues and discuss strategies to support the hospitals revenue goals.
- Coordinates with Network Management on needs to support payor contracting
- Coordinates with Patient Financial Services and Controller to address claim and authorization rejections due to credentialing, and initiate appropriate actions to reverse denials.
- Coordinates projects as needed with payors and SHC departments
- Ensures appropriate reporting occurs to national payors for enrollment and offboarding of providers. Supports the Provider Enrollment Specialists with resolving issues as needed.
- Cross trains with "Health Plan Liaison – Medicaid & Medicare", and assists with duties as needed, to ensure timely deliverables, coverage, and business continuance.
- Plans and manages projects as needed

Job Requirements

The qualified candidate will have experience in the following areas:

- Three years of direct experience with managed care, third party and government insurance provider enrollment required
- NCQA auditing and/or accreditation experienced preferred
- Medicare/Multi-state Medicaid experience preferred
- Knowledge, development and implementation of enrollment workflow processes preferred
- Must have excellent computer skills (documentation, database management, spreadsheets), Adobe Pro, Microsoft Office Applications (Excel, Word, Outlook, PowerPoint, etc.)
- Demonstrated experience with change management and ability to influence people not in a direct reporting relationship preferred

Minimum Education Required/Preferred

- Associates Degree in Business or Healthcare related field, or equivalent work experience, required
- Bachelor's Degree preferred

Knowledge, Skills, And Competencies

- Demonstrates ability to exercise discretion and independent judgment, including using various resources and seeking input from appropriate personnel throughout the organization in decision-making process, to address issues, and provide guidance to hospitals
- Coordinates inter-departmental efforts to improve processes in the organization
- Ability to speak effectively before a group, conduct training sessions and conferences
- Ability to adapt to flexible work schedules and frequent interruptions
- Ability to problem solve, and effectively negotiate conflict
- Knowledge of healthcare environment and healthcare delivery systems
- Knowledge of medical provider credentialing procedures and standards
- Data management skills including querying, reporting, and document generation
- Maintains strict confidentiality with regard to provider information and understands/adheres to HIPAA Privacy & Security policies and procedures
- Well-organized, detail oriented and able to meet deadlines with minimal errors
- Strong written, phone, and verbal communication skills; proven ability to communicate with physicians and leadership
- Must be able to lead and work cohesively in a team-oriented environment and be able to foster good working relationships with others both within and outside the organization
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SDL2019-258

WellCare Health Plans hiring Licensed Health Insurance Agent in Memphis, TN, US

SourceURL: https://www.linkedin.com/jobs/view/licensed-health-insurance-agent-at-wellcare-health-plans-887445934

Prospects for and enrolls eligible leads into the Medicare Advantage plans. Meets the minimum enrollment goal of new members using approved presentation materials and sales techniques.

Reports to: Manager, Sales

Department: Sales

Location: Memphis, TN

Essential Functions

- Utilizes territorial model philosophy to maximize marketing efforts in attaining new enrollments.
- Generates referrals utilizing community resources, supplied company tools, event planning and community networking.
- Prospects for leads and converts leads into appointments.
- Converts appointments into enrollments.
- Maintains disenrollment rate that is deemed acceptable from the company.
- Coordinates and conducts approved marketing events.
- Achieves corporate enrollment goals.
- Strictly adheres to all CMS and WellCare Marketing regulations.
- Performs other duties as assigned.

Additional Responsibilities:

- Reviews, quality checks and accurately enters all data/enrollment paperwork into electronic application.
- Creates flyers, pamphlets and event material to support field based lead generation activities
- May be asked to support and travel to other markets from time to time.
- Conducts new member orientation.
- Contacts approved leads by telephone to set appointments.

Candidate Education:

- Required A High School or GED

Candidate Experience:

- Required Other Sales Experience
- Preferred 2 years of experience in Sales
- Preferred Other Event planning experience

Candidate Skills:

- Intermediate Demonstrated organizational skills
- Intermediate Knowledge of healthcare delivery
- Intermediate Ability to work independently
- Intermediate Demonstrated negotiation skills
- Intermediate Knowledge of community, state and federal laws and resources
- Intermediate Ability to represent the company with external constituents
- Intermediate Demonstrated interpersonal/verbal communication skills
- Intermediate Ability to multi-task
- Intermediate Demonstrated customer service skills
- Intermediate Ability to effectively present information and respond to questions from families, members, and providers
- Intermediate Demonstrated ability to deal with confidential information
- Intermediate Other Goal and result driven in sales
- Intermediate Other Ability to pay close attention to detail

Licenses and Certifications:

A License In One Of The Following Is Required

- Required Other Medicare Sales Certification and Recertification OR
- Required Other Medicare Sales Certification must be obtained within 90 days of hire
- Required Other Licensed Health Insurance
- Required Other Valid Driver's License

Technical Skills:

- Required Intermediate Microsoft Word
- Required Intermediate Microsoft Excel
- Required Intermediate Microsoft Outlook

Languages:

- Preferred Other the Baton Rouge, LA market may require Vietnamese speaking candidates/associates

About Us

Headquartered in Tampa, Fla., WellCare Health Plans, Inc. (NYSE: WCG) focuses primarily on providing government-sponsored managed care services to families, children, seniors and individuals with complex medical needs primarily through Medicaid, Medicare Advantage and Medicare Prescription Drug Plans, as well as individuals in the Health Insurance Marketplace. WellCare serves approximately 5.5 million members nationwide as of September 30, 2018. WellCare is a Fortune 500 company that employs nearly 12,000 associates across the country and was ranked a "World's Most Admired Company" in 2018 by Fortune magazine. For more information about WellCare, please visit the company's website at www.wellcare.com. EOE: All qualified applicants shall receive consideration for employment without regard to race, color, religion, creed, age, sex, pregnancy, veteran status, marital status, sexual orientation, gender identity or expression, national origin, ancestry, disability, genetic information, childbirth or related medical condition or other legally protected basis protected by applicable federal or state law except where a bona fide occupational qualification applies. Comprehensive Health Management, Inc. is an equal opportunity employer, M/F/D/V/SO.

Molina Healthcare hiring VP, Government Contracts in Midvale, UT, US

SourceURL: https://www.linkedin.com/jobs/view/vp-government-contracts-at-molina-healthcare-1307368792

Job Summary

Responsible for the strategic development and administration of contracts with State and/or Federal governments for Medicaid, Medicare, Marketplace, and other government-sponsored programs to provide health care services to low income, uninsured, and other populations.

Knowledge/Skills/Abilities

- Oversees the strategic development and administration of contracts with the State and/or Federal government for Medicaid, Medicare, Marketplace, and other government-sponsored programs to provide health care services to low-income, uninsured, and other populations.

- Serves as lead for contract knowledge and assists Plan President with various advocacy efforts in support of Plan business operations.
- Provides leadership on emerging health care issues, new business implementation, and strategic planning for the health plan.
- Provides contracts and relationship management for State and Federal partners (Medicaid, Medicare, Insurance) and key State elected officials (Governor's Office, State legislators, and local government officials).
- Leads and supervises Regulatory Submissions and Filings.
- Represents Molina at State and local meetings including those with leadership of the Department of Health Care Services, Department of Managed Health Care, Department of Insurance, and other agencies. Develops strategies to advocate for best practices that demonstratively improve contract terms or facilitate business objectives.
- Leads efforts with Plan President to expand managed care and other health plan business opportunities (such as duals, SPDs, Accountable Care Act (ACA) Marketplace participation and Medi-Cal expansion, and accountable care organization (ACO) delivery models).
- Improves coordination/integration of acute and long-term services and supports (LTSS) for dual eligible and Medi-Cal seniors and persons with disabilities (SPDs), and influences the State's implementation of the ACA provisions.
- Represents Molina with key industry groups such as the state's Association of Health Plans, AHIP, Medicaid Health Plans of America (MHPA), and NAIC. Also works with key statewide advocacy groups and provider trade associations to advocate Molina's position and business objectives and develop strategic partnerships.
- Works with Legal Affairs to assess and provide analyses for proposed changes to Medicaid, Medicare, Exchange, and other government-sponsored healthcare program contracts, governing regulations and new legislation and policy requirements.
- Oversees and monitors the implementation of new Medicaid and Medicare contractual and policy requirements, new legislation and regulations.
- Coordinates plan's RFI responses, as well as RFA and RFP bid efforts, in collaboration with MHI Corporate Development.**Job Qualifications**

Required Education

Job Qualifications

Bachelor's Degree in related field or equivalent combination of education and experience.

Required Experience

- 7+ years experience in government programs and 2+ years management experience.
- Extensive knowledge of Medicaid, Medicare, Marketplace and/or other government-sponsored programs.

Required License, Certification, Association

N/A

Preferred Education

J.D. or a Masters Degree in Public Health, Public Policy or Business Administration.

Preferred Experience

Experience working in the managed care industry, particularly with health plans that contract with government-sponsored programs .

Preferred License, Certification, Association

N/A

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

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

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

Primary Location

US-UT-Midvale-UTAH

Job

Health Plans

Organization

Health Plans

Job Posting

Jun 7, 2019, 5:54:40 PM

- **Seniority level**

  Executive

- **Employment type**

  Full-time

- **Job function**

  ManagementManufacturing

- **Industries**

  Hospital & Health Care

DOM-Medicaid Program Nurse III

SourceURL: https://www.governmentjobs.com/jobs/2471982-0/dom-medicaid-program-nurse-iii?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Characteristics of Work

The DOM-Medicaid Program Nurse III practices professional nursing under the direct or indirect supervision of the Medicaid-Program Nurse Director or the DOM-Medicaid Nurse

Bureau Director. The work includes case finding, health teaching, health counseling, assessment, and evaluation of providers of services and related sites to ensure compliance with Medicaid Provider agreements, development, and review of Medicaid policies. Other duties include analyzing findings and recommending plans for correction to the providers. The incumbent may provide technical and programmatic guidance to nurses in the DOM-Medicaid Nurse I and DOM-Medicaid Nurse II classifications.

Examples of Work

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

Reviews and studies federal and state laws, rules, and regulations governing agency's compliance.

Interprets and explains Medicaid regulations and guidelines to providers, beneficiaries, families, and other groups.

Conducts workshops and/or on-site training to providers of service in order to improve skills and knowledge of Medicaid rules and regulations.

Reviews and analyzes trends pertinent to delivery of services to Medicaid beneficiaries.

Develops and recommends new and revised policies, procedures, plans, and strategies to respond to changes in program needs, objectives, and priorities and to improve the effectiveness of services.

Provides assistance in developing and implementing policy and procedures for detecting fraud and abuse of program services, mis-utilization of services by providers and beneficiaries, and utilization reviews.

Reviews and audits records, charts, and reports to determine if correct and appropriate services were given.

Monitors and evaluates providers of service and related provider sites to beneficiaries in the Medicaid program.

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 Master's Degree in Nursing;

AND

Experience:

Five (5) years of experience in nursing as a Registered Nurse/Nurse Practitioner and licensure as required below;

OR

Education:

Graduation from a state approved Nurse Practitioner program with credentials (certification);*

AND

Experience:

Five (5) years of experience in nursing as a Registered Nurse/Nurse Practitioner and licensure as required below;

OR

Education:

A Bachelor's Degree from an accredited four-year college or university in nursing;

AND

Experience:

Six (6) years of experience in nursing as a Registered Nurse/Nurse Practitioner and licensure as required below;
OR
Education:
A three-year diploma in nursing or a two-year Associate's Degree in nursing, and licensure as required below;
AND
Experience:
Seven (7) years of experience in nursing as a Registered Nurse/Nurse Practitioner and licensure as required below;
OR
Experience:
One (1) year as a DOM-Medicaid Program Nurse II, or three (3) years as a DOM-Medicaid Program Nurse I, and licensure as required below.
Certification/Licensure Requirements:
Must have a valid license to practice as a Registered Nurse and/or Nurse Practitioner in the State of Mississippi.
*Must possess approved certificate in area of practice.
Documentation Required:
Applicant must attach a valid copy of his/her license to practice as a Registered Nurse and/or Nurse Practitioner in the State of Mississippi.
INTERVIEW REQUIREMENTS:
Any candidate who is called to an agency for an interview must notify the interviewing agency in writing of any reasonable accommodation needed prior to the date of the interview.

Health Insurance Specialist Special Assistant Job in NEW YORK, NY

SourceURL: http://federalgovernmentjobs.us/jobs/Health-Insurance-Specialist-Special-Assistant-535353400.html?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Requirements
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) Evaluating management procedures or practices to recommend improvements to effectively/efficiently achieve an organization goals; 2) Using analytical skills and evaluation methods to develop and prepare reports and analyses AND; 3) Evaluating the effectiveness of existing or new policies for potential impact on 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.

Time-in-Grade: To be eligible, current or former Federal employees and current or former Federal employees applying under the VEOA eligibility who hold or have held a permanent General Schedule position in the previous year 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:
https://apply.usastaffing.gov/ViewQuestionnaire/10516695
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: 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 Office of Personnel Management (OPM) Salaries & Wages Page.

Additional Forms REQUIRED Prior to Appointment:

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

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. Click here for a detailed description of the required supporting documents. A well-qualified applicant is one whose knowledge, skills and abilities clearly exceed the minimum qualification requirements of the position. Additional information

about ICTAP and CTAP eligibility is on OPM's Career Transition Resources website at www.opm.gov/rif/employee_guides/career_transition.asp.

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 Alternate Application.
How You Will Be Evaluated

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):

- Administration and Management
- Analysis
- Oral Communication
- Written Communication

Background checks and security clearance
Security clearance

Not Required

Drug test required

No

Position sensitivity and risk

Non-sensitive (NS)/Low Risk

Trust determination process

Credentialing, Suitability/Fitness