Medicaid Medical Director - Medical Specialist 4 - Job at Minnesota Department of Human Services

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Medicaid Jobs Hunter

In this packet....

Medicaid Medical Director - Medical Specialist 4 - Job at Minnesota Department of Human Services

Job Description

Job Class: Medical Specialist 4Working Title: Medicaid Medical Director
Who May Apply: Open to all qualified job seekers

Closing Date: Will remain posted until filled

Hiring Agency/Seniority Unit: Department of Human Services / DHS Excluded Others

Division/Unit: Health Care Administration / Assistant Commissioner Medicaid Director

Work Shift/Work Hours: Day Shift / Varies

Days of Work: Monday-Friday

Salary Range: $83.22 - $124.55/hourly, part-time or full-time

Classified Status: Unclassified

: No

Job Summary
The Medicaid Medical Director position is a unique opportunity to provide medical leadership in the State of Minnesota. This position is the medical leader on medical and clinical matters related to the Medicaid and MinnesotaCare programs. This includes representing and speaking on behalf of the Department of Human Services (DHS).

This involves interfacing with the DHS Commissioner's Office and leadership, external stakeholders, federal officials, the provider community, the media, and the Legislature.

Together with the Behavioral Health Clinical Director, this position will work to address health disparities, health access and the integration of care across Minnesota, particularly in physical and behavioral health services in Medicaid, and new models of care. Responsibilities include working across DHS to address social determinants of health.

Qualifications

Minimum Qualifications:
Five (5) years of clinical experience as a practicing physician demonstrating the following:

- Must be a board-certified medical doctor with unencumbered licensed to practice medicine in Minnesota;
- Three (3) years of serving Medicaid and/or MinnesotaCare enrollees;
- Demonstrated leadership experience in health care management, public health, and policy-making;
- Experience developing and implementing evidence-based practice models in clinical settings that focus on reducing disparities, addressing the full spectrum of care, and measurement of outcomes.

Preferred Qualifications:

- Ability to be data driven, with a working knowledge of management information systems, statistical analysis, and outcome data analysis
- Experience with the development and implementation of practice guidelines
- Proven record of efforts to address health disparities
- Experience working in multiple care settings and that see a high percentage of Medicaid
- Implementation experience in change management
- Strong written and oral communication skills, including the ability to articulate issues in a concise manner, accessible to a wide range of audiences
- Extensive understanding of the health care delivery system and the health care marketplace within and around the state of Minnesota
- Understanding of the basic authority (state and federal law and rules) governing the Medicaid and MinnesotaCare programs
- Understanding of other state and federal health care programs and policies and their connection to Medicaid
- Understanding of how to participate in the legislative process as a lead professional state agency representative
- Effective interpersonal influence, collaboration and listening skills
- Leadership skills necessary to analyze and articulate complex policy concepts, envision change, and promote creative and innovative approaches in a respectful and inclusive manner

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

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

Application Details

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

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

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

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

For additional information about the application process, go to .

Contact
If you have questions about the position, contact Julie Marquardt at

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

AN EQUAL OPPORTUNITY EMPLOYER

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

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

STAR+PLUS Manager/Service Coordination/RN

Job Description

	About Us
	Community Health Choice, Inc. (Community) is a non-profit managed care organization (MCO), licensed by the Texas Department of Insurance. Through its network of more than 10,000 providers and 94 hospitals, Community serves over 400,000 Members with the following programs: • Medicaid State of Texas Access Reform (STAR) program for low-income children and pregnant women • Children's Health Insurance Program (CHIP) for the children of low-income parents, which includes CHIP Perinatal benefits for unborn children of pregnant women who do not qualify for Medicaid STAR • Health Insurance Marketplace Plans that offer individual health coverage that includes preventive care, emergency services, prescription drugs, and hospitalization available to all, regardless of pre-existing conditions. Improving Members' experiences is at the heart of every Community position. We strive every day to make sure that our Members have access to the high-quality health care they need and deserve. Community is accredited by URAC for its health plan operations. We offer care management programs for asthma, diabetes, and high-risk pregnancy. An affiliate of the Harris

	Health System (Harris Health), Community is financially self-sufficient and receives no financial support from Harris Health or from Harris County taxpayers.
	Job Profile
	The STAR+PLUS Manager, Service Coordination RN works with members, providers and multidisciplinary team members to assess, facilitate, plan and coordinate an integrated delivery of care across the continuum, including behavioral health and long term care, for members with high need potential. Community Health Choice (Community) staff work to ensure that patients¿ progress toward desired outcomes with quality care that is medically appropriate and cost-effective based on the severity of illness and the site of service. The STAR+PLUS Manager Service Coordination RN provides operational management and oversight of integrated STAR+PLUS teams responsible for providing Community members with the right care at the right place at the right time and assisting them to achieve optimal clinical, financial, and quality of life outcomes. QUALIFICATIONS: • Bachelor's or Master's Degree in Nursing, Gerontology, Public Health, or related field preferred. Registered Nurse License required. • One of the following preferred: Certified Case Manager (CCM), Certified Professional in Healthcare Management (CPHM), Certified Professional in Health Care Quality (CPHQ), or other healthcare or management certification. • Five years of managed healthcare experience, including three or more years in STAR+PLUS service coordination required. • Experience working within applicable state, federal, and

	third party regulations required. Medicaid/Medicare Population experience with increasing responsibility preferred. • Three years of clinical nursing experience preferred • One year of healthcare or health plan supervisory or managerial experience, including oversight of clinical staff required. OTHER SKILLS: • Above Average Verbal (Heavy Public Contact) • Exceptional Verbal (e.g., Public Speaking) • Bilingual (English/Spanish) preferred • Writing /Composing (Correspondence/ Reports) • Analytical • Medical Terminology • Research • MS Word • MS Excel
	Benefits and EEOC
	Community employees' benefits are provided by Harris Health. These benefits are designed to provide you with flexibility and choices in meeting your specific needs. Community is an Equal Opportunity Employer.
	Job Category
	All Jobs

Application Instructions

Please click on the link below to apply for this position. A new window

will open and direct you to apply at our corporate careers page. We look forward to hearing from you!

Apply Online

State of Florida 68010652-Systems Project Consultant Job in Tallahassee, FL

Source URL: https://www.glassdoor.com/job-listing/68010652-systems-project-consultant-state-of-florida-JV_IC1154378_KO0,35_KE36,52.htm?jl=3358929572&utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Job

Company

Rating

Salary

Reviews

Benefits

Requisition No: 78223

Agency: Agency for Health Care Administration

Working Title: 68010652-SYSTEMS PROJECT CONSULTANT

Position Number: 68010652

Salary: $1,673.36 BI WEEKLY

This is an exciting opportunity to help shape the quality of health care in Florida. The Agency for Health Care Administration (AHCA) is the State of Florida agency responsible for oversight of the Medicaid program. The Medicaid program provides low-income families and individuals with access to health care. If you have a desire to use your talent and skills at an organization that provides critical services to millions of individuals and families across the state, AHCA invites you to apply to become an essential member of our team. As one of Florida's leading state agencies, AHCA's diverse workforce community of more than 1,400 employees is proud of its efforts to serve the people of Florida.

We are seeking to hire a Systems Project Consultant who desires to work to enhance the delivery of health care services through the Florida Medicaid Program. This position requires a candidate who is creative, flexible, innovative, and who will thrive in a fast-paced, team based work environment.

This position is located in the Bureau of Medicaid Recipient and Provider Assistance (RPA). RPA serves as a primary point of contact for enrolled Medicaid providers, Medicaid recipients, and members of the

community with questions and concerns about Medicaid.

This position is responsible for work in a technical capacity as follows: 1) coordinating team(s) in the analysis, design, development and implementation of comprehensive management information systems; or 2) coordinating one or more primary functional areas related to Enrollment Broker and Recipient Support systems within the Enrollment Broker Operations Section.

The incumbent in this position assists in the coordination of technical work of project teams in systems planning studies, information needs assessments and systems analysis, reviewing approaches and methods to assess effectiveness in meeting management objectives.

The incumbent in this position serves as technical consultant to higher level supervisory and/or administrative personnel in the planning of major systems, including but not limited to communication of system priorities and allocation of available resources for the section.

The incumbent in this position consults with user business groups to gather business requirements and determine requirements for implementation of comprehensive management information systems.

The incumbent in this position coordinates implementation of technical changes recommended by project teams and the development of corollary training or support for systems implementation.

The incumbent in this position assures completeness and accuracy of the systems design, programming and implementation.

The incumbent in this position confers with program representatives in reviewing operations to identify management problem areas, specific information requirements and to discuss project findings.

The incumbent in this position coordinates and/or participates in the development and implementation of operational policies and plans for the integration of all departmental information systems.

The incumbent must maintain knowledge of the health care programs at AHCA, up-to-date knowledge of the Florida Medicaid Program, particularly as it relates to external systems and Enrollment Broker systems interfaces, data processing hardware and software, data warehousing; database management and programming techniques, security and confidentiality regulations, and state office administration requirements.

The incumbent in this position performs other duties and responsibilities as assigned.

AHCA offers an excellent array of benefits, including:

•Health insurance

•Life insurance

•Dental, vision and supplemental insurance

•Retirement benefits

•Vacation and sick leave

•Paid holidays

•Opportunities for career advancement

•Tuition waiver for public college courses

•Training opportunities

For more information about the Bureau of Medicaid Recipient and Provider Assistance, please visit our website at http://ahca.myflorida.com/Medicaid/index.shtml.

Join us at the Agency for Health Care Administration in fulfilling our mission to provide "Better Health Care for all Floridians."

KNOWLEDGE, SKILLS, AND ABILITIES:

- Knowledge of and experience with HTML, C Sharp and JavaScript compatible computer programming languages, computer operation procedures, and techniques of systems design, of all systems documentation standards including flow-charting techniques, program specifications, user documentation manuals and data element dictionaries.
- Ability to communicate data processing requirements for large-scale computer payment processing systems both verbally and in writing and to review output deliverables from the fiscal agent to assure compliance with the specifications, to identify and define computer hardware and software needs of Medicaid related programs including policy definitions, accounting-related outputs, and all federal and state mandated reports.
- Special communications ability related to transmitting technical information to agency managers and federal and state auditors in a manner that can be understood by non-technical managers, accountants, and auditors.

- Ability to plan, organize, coordinate and track numerous data processing projects to assure that all computer-related output deliverables are prepared by the Medicaid fiscal agent in accordance with contractual guidelines and timeframes.
- Knowledge and experience with the Florida Medicaid program.
- Working knowledge of Microsoft Excel and Microsoft Word.

MINIMUM QUALIFICATIONS:

- Two years of experience in computer systems analysis and / or computer programming and either
- Completion of a 720 classroom hour program of study from a vocational/technical school or commuting college in an area of data processing (excluding data entry) or
- 60 semester or 90 quarter hours of college course work from an institution which includes four courses in computer science or management information systems
- Experience as described above can substitute on a year for year basis for the required college education
- Completion of a one-year program of study from a vocational/technical school in an area of data processing (excluding data entry) can substitute for one year of the required experience.

CONTACT PERSON: KISSA SMITH 850-412-4186

The State of Florida is an Equal Opportunity Employer/Affirmative Action Employer, and does not tolerate discrimination or violence in the workplace.

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

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

VETERANS' PREFERENCE. Pursuant to Chapter 295, Florida Statutes, candidates eligible for Veterans' Preference will receive preference in employment for Career Service vacancies and are encouraged to apply. Candidates claiming Veterans' Preference must attach supporting documentation with each submission that includes character of service (for example, DD Form 214 Member Copy #4) along with any other documentation as required by Rule 55A-7, Florida Administrative Code. Veterans' Preference documentation requirements are available by clicking here. All documentation is due by the close of the vacancy announcement.

Medical Director Medicaid LOB | WellCare Health Plans

Source URL: https://www.linkedin.com/jobs/view/medical-director-medicaid-lob-at-wellcare-health-plans-1505513863/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

This position is contingent upon the bid award in the state of Texas to WellCare Health Plans, Inc

Oversees clinical direction of medical services and quality improvement functions at the health plan level. Provides medical management leadership for the health plan and, as applicable, manages all major clinical and quality program components under health plan operations. Oversees medical coordination required for effective utilization and quality management of the health plan network. Functions as medical leadership for effective care integration of WellCare pharmacy operations, utilization/case/disease Management activities, quality improvement activities, and provider relations functions.

Essential Functions

- Collaborates with the organization's senior leadership to ensure medical compliance with all customer, regulatory, and accreditation requirements for clinical services.
- Provides current medical expertise and direction for clinical policies, procedures and programs.
- As required by business and operational priorities, establishes professional working relationships with providers and provider organizations to support the development of the highest possible provider partnerships.
- Manages day-to-day quality improvement and medical management activities.
- Establishes and is accountable for health plan utilization, OS applications and quality outcomes.
- Assures all internal and vendor medical review activities conform to company protocols, customer requirements, and professional standards.
- Ensures adherence to assigned budget accountabilities.
- Works closely with other medical directors and clinical services staff to attain and/or maintain compliance with company, customer, accreditation and regulatory requirements.
- Provides clinical expertise needed to effectively and efficiency resolve complex, controversial and/or unique administrative circumstances.

- Provides clinical guidance for sales, marketing, legal, regulatory affairs, financial, operational, and related business activities.
- As requested and needed, provides expert medical education, consultation, and supervision for the clinical staff.
- Provides medical leadership for development and attainment of the organization's goals.
- Support provider relations and risk contracting through education, provider visits and problem resolution
- Collaborates with corporate care management to establish and implement clinical programs to support and meet care management goals
- Manages the application of all clinical aspects of the Credentialing Program, Credentialing Committee and Peer Review activities at the state level.
- Shares responsibility for quality improvement and accreditation initiatives in the assigned market(s)
- Develops value propositions for clinical programs through quantitative analytics, ROI and evidence-based data
- Initiates dialogue with providers, as necessary, to resolve differences in opinions concerning utilization management. Reviews and makes determinations regarding provider appeals.
- Ensure compliance with federal, state and NCQA standards
- Oversees provider education regarding pharmacy, utilization, quality improvement and responsible health care expenditures to improve clinical outcomes
- Establishes and maintains relationships with key stakeholders in partnership with the market leadership
- Provides medical accountability in fulfilling the company's compliance with customer audits and reports, and accreditation surveys.
- Performs other duties as assigned.

Additional Responsibilities:

<u>Candidate Education</u>

- Required A Doctor in Medicine (MD) or D.O. from an accredited school of medicine recognized by national medical regulatory

bodies in the United States

Candidate Experience:

- Required 5 years of experience in direct patient care
- Required Other Substantial experience and expertise in the development of medical policies, procedures and programs
- Required Other Demonstrated success implementing utilization and quality improvement strategies /techniques and experience with physician behavior modification
- Preferred Other Qualifications to perform clinical oversight for the services provided by the health plan to include but not limited to: Education, training or professional experience in medical or clinical practice
- Preferred Other Past participation in a managed care UM committee

Candidate Skills:

- Advanced Ability to communicate and make recommendations to upper management
- Advanced Ability to effectively present information and respond to questions from families, members, and providers
- Advanced Ability to create, review and interpret treatment plans
- Advanced Demonstrated leadership skills
- Advanced Ability to work in a fast paced environment with changing priorities
- Advanced Demonstrated interpersonal/verbal communication skills
- Advanced Demonstrated organizational skills
- Advanced Demonstrated ability to deal with confidential information
- Advanced Ability to represent the company with external constituents
- Advanced Demonstrated negotiation skills
- Advanced Ability to influence internal and external constituents
- Advanced Other Ability to remain calm under pressure
- Advanced Other Must be able to apply medical knowledge and

principles to business challenges in order to achieve significant member, business, and quality outcomes
- Advanced Other Must be detail-oriented and have a “hands-on” approach
- Advanced Other Clear understanding of the managed care field and managed care operating components, with emphasis on clinical management of health services, particularly within an integrated managed care model
- Advanced Other Clear understanding of regulatory systems and processes that affect managed care health system

Licenses and Certifications:
- Required
- Required An unrestricted and current license to practice medicine in the state of employement (or the ability to obtain one)
- Required Board Certification

Technical Skills:
- Required Intermediate Microsoft Excel
- Required Intermediate Microsoft Word
- Required Intermediate Microsoft PowerPoint
- Required Intermediate Microsoft Visio
- Required Intermediate Microsoft Outlook

Languages:

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.

MyFlorida 68059450 - Government Operations Consultant II in Virtual, USA, United States

Source URL: https://veterans.usnlx.com/virtual-usa/68059450-government-operations-consultant-ii/47C033283D5340929B2AA5CD2972D35F/job/?vs=28&utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Location:FORT LAUDERDALE, FL, US, 33309

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The State Personnel System is an E-Verify employer. For more information click on ourE-Verify website.

Requisition No: 76601

Agency: Agency for Health Care Administration

Working Title: 68059450 - GOVERNMENT OPERATIONS CONSULTANT II

Position Number: 68059450

Salary: $1,486.92 - $1,588.77 / Bi-Weekly

Posting Closing Date: 10/02/2019

This is an exciting opportunity to help shape the quality of health care in Florida. The Agency for Health Care Administration (AHCA) is the State of Florida agency responsible for oversight of the Medicaid program. The Medicaid program provides low-income families and individuals with access to health care. If you have a desire to use your talent and skills at an organization that provides critical services to millions of individuals and families across the state, AHCA invites you to apply to become an essential member of our team. As one of Florida's leading state agencies, AHCA's diverse workforce community of more than 1,400 employees is proud of its efforts to serve the people of Florida.

We are seeking to hire Government Operations Consultant II who desires to work to enhance the delivery of health care services through the Florida Medicaid Program. This position requires a candidate who is creative, flexible, innovative, and who will thrive in a fast-paced, team based work environment.

This position is located in the Bureau of Medicaid Plan Management Operations (PMO). PMO is responsible for the primary oversight of Medicaid's managed care programs, with a focus on the Statewide Medicaid Managed Care (SMMC) program. The bureau's primary responsibility is ensuring that the managed care plans meet Medicaid

contractual requirements, including the timely provision of medically needed services and provider payment for such services.

This position is responsible for reviewing Medicaid managed care claim complaints and determining managed care compliance with the SMMC contract as it relates to claims processing.

Examples of work include:

Analyzes programmatic reports of claims and provider reimbursement issues/complaints to determine managed care plan compliance with contract provisions.

Coordinates and performs monitoring of Medicaid Managed Care Plan claim submission protocols and standard claim processing procedures through the review of claim complaints, claim forms, explanation of benefits, and authorization in order to make a compliance determination.

Follows established unit policies and procedures to ensure the compliance process is conducted in a consistent manner and review findings are documented appropriately.

Analyzes compliance issues and makes recommendation for compliance actions when issues are identified in the managed care plan provider reimbursement and claims processes.

Conducts program training and provides technical assistance to Medicaid managed care plans related to compliance with contract provisions, provider reimbursement and claims processing requirements.

Maintains up-to-date knowledge concerning the Florida Medicaid Program.

Participates in meetings, prepares and delivers speeches with the

Agency, with managed care organizations and other stakeholders.

Represent Medicaid on health related committees, task forces, and special projects, as assigned.

Performs other duties, as assigned.

This position may require travel.

AHCA offers an excellent array of benefits, including:

- Health insurance
- Life insurance
- Dental, vision and supplemental insurance
- Retirement benefits
- Vacation and sick leave
- Paid holidays
- Opportunities for career advancement
- Tuition waiver for public college courses
- Training opportunities

  For more information about the Bureau of Plan Management Operations, please visit our website at http://ahca.myflorida.com/Medicaid/index.shtml. Join us at the Agency for Health Care Administration in fulfilling our mission to provide “Better Health Care for all Floridians.” This advertisement is being used to fill multiple positions. KNOWLEDGE, SKILLS, AND ABILITIES
- Knowledge of Medicaid eligibility, programs, policies, and limitations.
- Knowledge of the methods of data collection and analysis.
- Knowledge of and ability to effectively utilize computer skills such as Microsoft Office 2016(Word, Excel, Outlook, Power Point and Access).
- Knowledge of the techniques used in compiling and analyzing data.
- Ability to collect, evaluate and analyze data to develop alternative recommendations, solve problems, document work flow and other

activities related to the improvement of operations.

- Ability to organize data in a logical format for presentation in reports, documents and other written materials.
- Ability to conduct fact-finding research.
- Ability to utilize problem-solving techniques.
- Ability to work independently.
- Ability to understand and apply applicable rules, regulations, policies and procedures relating to operational activities.
- Ability to make decisions in a timely manner.
- Ability to verify accuracy of data.
- Ability to establish and maintain effective working relationships with all levels of staff.
- Possesses effective verbal and written communication skills.
- Effective multi-tasking skills.
- Ability to travel with or without accommodations.

MINIMUM QUALIFICATION REQUIREMENTS

- At least two years of related work experience with health insurance claims billing (commercial/government programs) is required.
- At least two years of experience conducting monitoring activities related to a healthcare program is required.
- At least two years of experience interpreting policies and procedures and providing technical assistance.
- At least two years of experience using computers and various software programs such as Outlook, Word, Excel, Access and PowerPoint.

A Bachelor's Degree or degree in a healthcare field from an accredited college or university is preferred.Professional or non-professional experience as described above can substitute on a year-for-year basis for the preferred college education. LICENSURE, CERTIFICATION, OR REGISTRATION REQUIREMENTSN/A CONTACT:TERESA YODER-TRAU 954-958-6550

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the workplace.

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Nearest Major Market:Fort LauderdaleNearest Secondary Market:Miami

General Eligibility Policy Specialist. | State of Colorado

Source URL: https://www.linkedin.com/jobs/view/general-eligibility-policy-specialist-at-state-of-colorado-1513285990/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Department Information

The Medicaid Operations Office

Make a difference-Join HCPF by improving health care access and outcomes for the people we serve while demonstrating stewardship of financial resources.

The Department of Health Care Policy and Financing (Department) offers a competitive benefits package to include the Public Employees Retirement Account (PERA), 401k/457, health/dental insurance options, 10 holidays, accrual of paid sick and vacation/annual time, flex place and flex time. The Department is also centrally located; offers affordable ECO passes; has a fitness center on-site; and a variety of discounts on services and products are available to state employees through the State of Colorado's Work-Life Employment Discount Program. The Department also encourages employees to take advantage of advanced education and offers reduced college tuition through CSU Global for their employees. This Department is a "Tobacco Free Workplace". http://www.colorado.gov/hcpf

The Medicaid Operations Office oversees health plan operations administered by the Department. This office is responsible for the overall operations of Medicaid, including Child Health Plan *Plus* (CHP+). This office manages the daily operations of Medicaid to ensure compliance with Federal and State laws, rules and regulations. In addition, this office is responsible for establishing

and monitoring the operational performance standards (e.g., call center performance standards, claims payment standards, enrollment processing standard, etc.) for contractors working for the Department. This office establishes systems for robust monitoring of health plan operations, oversees the collection of information necessary for performance monitoring and directs staff reviews to identify and mitigate compliance risks. This office has oversight of claims payment operations, the member and provider call centers; the member identification card contractor; and eligibility determinations made by eligibility sites and monitoring of county partners.

The Eligibility Policy Section, located in the Medicaid Operations Office, is responsible for policy regarding an individual's eligibility for Medical Assistance Programs. This includes interpreting state and federal regulations concerning eligibility across a number of categorical assistance programs, ensuring compliance with state and federal regulations and laws, and enrolling individual's onto Medical Assistance Programs through the application process and Colorado Benefits Management System (CBMS). This is accomplished through research, analysis, written and verbal communication with Medicaid individual's, eligibility workers, and high-level program groups, and formal training for field agents (i.e., county departments of social/human services, options for long-term care, medical assistance sites).

Description of Job

Position serves as a policy lead for the MAGI (Family and Children's Medicaid and CHP+) Medical Programs. Position has the authority and responsibility for the administration, implementation, and oversight of all aspects of MAGI-Medical Assistance Program eligibility. This includes but is not limited to: having a thorough understanding of the federal regulations, interpreting the regulations, providing policy suggestions for state options, and facilitating and soliciting stakeholder input.

Position is responsible for maintaining a strong working knowledge of the MAGI-Medical Assistance programs for the purpose of providing general support to members and staff. This also includes understanding the relationship between Family and Children's Medicaid and CHP+ and all other Medical Assistance programs for overall program impact.

This position is responsible to provide MAGI-Medical Assistance eligibility policy guidance to the Department. This position is responsible for researching and analyzing policy issues, directing rule and memo letter changes, updating State Plan Amendments to align with rule updates, preparing fiscal reports, and working with statewide eligibility sites and members on eligibility issues. This position is the lead in researching the federal and state laws/regulations for the further development of Family and Children's Medicaid and CHP+ eligibility policy and rule writing. This position assesses the need for methods to implement educational engagement with stakeholders. The position collaborates in the design and development of standardized training material and tools for statewide distribution. This position is responsible for communicating changes through formal written materials and participation in conferences and workgroups. This position is also the policy lead that collaborates with Connect for Health Colorado (C4HCO) as it relates to the MAGI programs. This includes but is not limited to having familiarity of Marketplace Federal regulations, interpreting the regulations, and providing policy suggestions for state options. Position is responsible for a working knowledge of all Insurance Affordability Programs (lAP) for the purpose of providing general support to members and staff. This also includes understanding the relationship between lAP and all Medical Assistance programs for overall program impact. Position will be a resource in reviewing, researching, and responding to appeals as they relate to the lAP eligibility populations. This position requires some in-state and overnight travel, and flexibility with work hours to

accommodate the needs of our customers.

Minimum Qualifications

Minimum Qualifications, Substitutions, Conditions of Employment & Appeal Rights

Education And Experience

Bachelor's degree from an accredited institution in a field of study related to the work assignment. Two years of professional experience in an occupational field related to the work assigned to the position. A minimum of 6 months of professional experience with researching and applying Medicaid eligibility policy and/or experience interpreting Medicaid federal and state regulations and laws.

Substitutions

Additional appropriate experience will substitute for the degree requirement on a year-for-year basis. Additional appropriate education will substitute for required experience on a year-for-year basis.

Preferred Qualifications

- Experience with program development involving complex problem resolution

- Prior experience working with diverse stakeholders or managing stakeholder relations
- Creativity and innovation including the ability to come up with unusual or clever ideas about a given topic or situation, or to develop creative ways to present materials
- Ability to set and prioritize workload, develop a work plan with tasks, time frames, milestones, resources, and dependencies
- Strong communication skills, verbal and written; and
- Ability to be self-motivated and self-directed, while possessing the ability to work in a team environment.

DEFINITION OF PROFESSIONAL EXPERIENCE: Work that involves exercising discretion, analytical skill, judgment, and personal accountability, and responsibility for creating, developing, integrating, applying, and sharing an organized body of knowledge that characteristically is uniquely acquired through an intense education or training regimen at a recognized college or university; equivalent to the curriculum requirements for a bachelor's or higher degree with major study in or pertinent to the specialized field; and continuously studied to explore, extend, and use additional discoveries, interpretations, and application and to improve data, materials, equipment, applications and methods.

Conditions Of Employment

- All positions at HCPF are security sensitive positions and require that the individuals undergo a criminal record background check as a condition of employment.
- Employees who have been disciplinarily terminated, resigned in lieu of disciplinary termination, or negotiated their termination from the State of Colorado must disclosed this information on the application.

Appeal Rights

If you receive notice that you have been eliminated from consideration for the position, you may protest the action by filing an appeal with the State Personnel Board/State Personnel Director within 10 days from the date you receive notice of the elimination.

Also, if you wish to challenge the selection and comparative analysis process, you may file an appeal with the State Personnel Board/State Personnel Director within 10 days from the receipt of notice or knowledge of the action you are challenging.

Refer to Chapters 4 and 8 of the State Personnel Board Rules and Personnel Director's Administrative Procedures, 4 CCR 801, for more information about the appeals process. The State Personnel Board Rules and Personnel Director's Administrative Procedures are available at www.colorado.gov/spb.

A standard appeal form is available at: www.colorado.gov/spb. If you appeal, your appeal must be submitted in writing on the official appeal form, signed by you or your representative, and received at the following address within 10 days of your receipt of notice or knowledge of the action: Colorado State Personnel Board/State Personnel Director, Attn: Appeals Processing, 1525 Sherman Street, 4th Floor, Denver, CO 80203. Fax: 303-866-5038. Phone: 303-866-3300. The ten-day deadline and these appeal procedures also apply to all charges of discrimination.

Director Office Of Strategy Performance and Results Job in BALTIMORE, MD

Vacancy No.	HHS-CMS-ES-2019-10598295	Department	Centers for Medicare & Medicaid Services
Salary	$127,914.00 to $192,300.00	Grade	00 to 00
Perm/Temp	Permanent	FT/PT	Full-time
Open Date	9/16/2019	Close Date	10/16/2019
Job Link	Apply Online	Who may apply	Status Candidates

Locations:

BALTIMORE, MD

Job Description (Please follow all instructions carefully)

- Service
  Senior Executive
- Pay scale & grade
  ES 00
- Salary
  $127,914 to $192,300 per year
- Appointment type
  Permanent
- Work schedule
  Full-Time

Locations
1 vacancy in the following location:

- Baltimore, MD

Relocation expenses reimbursed
No

Telework eligible
No

This job is open to

- **Senior executives**

  Those who meet the five Executive Core Qualifications (ECQs).

- **The public**

  U.S. citizens, nationals or those who owe allegiance to the U.S.

Clarification from the agency

All groups of qualified individuals

Announcement number
HHS-CMS-ES-2019-10598295

Control number
545695800

- Videos
  Videos
  https://www.youtube.com/embed/GbIL8Yn-jH0
- Duties
  Duties Summary
  This position is located in the Office of the Chief Operating Officer, Office of the Administrator within CMS, in Baltimore, MD.

  As the Director, Office of Strategy, Performance, and Results, you will provide strategic guidance and leadership for CMS' enterprise wide functions of strategic planning and monitoring, enterprise reporting, continuous improvement and modernization, and enterprise risk management.

  Learn more about this agency

  Responsibilities
  - Provide overall direction, executive leadership and guidance on the annual CMS strategic planning cycle.
  - Lead an ongoing program for monitoring and progress in achieving the Agency goals and objectives, including facilitating a process for identifying and implementing adjustments and course corrections as needed.
  - Plan and direct the development and maintenance of a CMS wide reporting system for key mission, customer service, program, and operational objectives including metrics and

measures.
    - Direct a program to support continuous improvement and modernization initiatives at CMS including the use of approaches like Lean, Agile, human-centered design, and other strategies for achieving lasting change in processes and organizations.
    - Develop and direct an Enterprise Risk Management program that enhances CMS' enterprise-wide decision making capabilities and risk mitigation capacity.
    - Provide briefings to the Administrator and other senior leaders in CMS and HHS on CMS capabilities related to strategic planning, continuous improvement, and enterprise risk management.

  Travel Required
  Occasional travel - You may be expected to travel for this position.

  Supervisory status
  Yes

  Promotion Potential
  00
- Job family (Series)
  0340 Program Management
- Requirements
  Requirements Conditions Of Employment
    - U.S. Citizenship required.
    - Background and/or Security Investigation required.
    - One year SES probationary period required.
    - The Ethics in Government Act, PL 95-521 requires the applicant selected for this position to submit a financial disclosure statement, SF-278, prior to assuming the SES position, annually, and upon termination of employment.
    - Status applicants must submit a copy of their most recent SF-50, Notification of Personnel Action, which verifies status.

- All initial appointments to an SES position are contingent on approval from OPM's Qualifications Review Board unless the selectee has successfully participated in an OPM approved SES Candidate Development Program.
- Aall male applicants born after December 31, 1959, must have registered for the selective service. You will be required to sign a statement certifying his registration, or the applicant must demonstrate exempt status under the Selective Service Law.
- Only experience obtained by the closing date of this announcement will be considered.

Qualifications
All competitive candidates for SES positions with the Federal Government must demonstrate leadership experience indicative of senior executive level management capability. To meet the minimum qualification requirements for this position, you must show in your resume that you possess the Fundamental Competencies, five Executive Core Qualifications, and the Professional/Technical Qualifications listed below. Evidence of this experience must be incorporated into your five page resume. Separate narratives for the Executive Core Qualifications and/or Professional/Technical Qualifications will not be accepted or considered. Typically, experience of this nature is gained at or above the GS-15 grade level in the Federal service, or its equivalent with state or local government, the private sector, or nongovernmental organizations.

Fundamental Competencies:

Interpersonal Skills, Oral Communication, Integrity/Honesty, Written Communication, Continual Learning, and Public Service Motivation.

Executive Core Qualifications (ECQs)

1. Leading Change: The ability to bring about strategic change, both within and outside the organization, to meet organizational goals. Inherent to this ECQ is the ability to establish an organizational vision and to implement it in a continuously changing environment.
2. Leading People: The ability to lead people toward meeting the organization's vision, mission, and goals. Inherent to this ECQ is the ability to provide an inclusive workplace that fosters the development of others, facilitates cooperation and teamwork, and supports constructive resolution of conflicts.
3. Results Driven: The ability to meet organizational goals and customer expectations. Inherent to this ECQ is the ability to make decisions that produce high-quality results by applying technical knowledge, analyzing problems, and calculating risks.
4. Business Acumen: The ability to manage human, financial, and information resources strategically.
5. Building Coalitions: The ability to build coalitions internally and with other Federal agencies, State and local governments, nonprofit and private sector organizations, foreign governments, or international organizations to achieve common goals.

Professional/Technical Qualifications (PTQs)

This position also requires that you possess PTQs that represent knowledge, skills, and abilities essential for success in this role. The following PTQs must be evident in your resume.

1. Demonstrated experience in strategic planning and organizational performance management and reporting to successfully achieve program goals.
2. Experience leading an organization to improve administrative operations through the use of business process modernization, setting priorities for current and future initiatives, allocating resources, and providing oversight of various complex and

sensitive programs.
3. Demonstrated experience leading a customer service oriented approach to strategy, performance management, and continuous improvement.

It is STRONGLY recommended that you visit the following Office of Personnel Management (OPM) website for more information regarding the Fundamental Competencies and ECQs.

https://www.opm.gov/policy-data-oversight/senior-executive-service/executive-core-qualifications/#url=Overview

If selected, you will be required to complete an ECQ package by drafting narratives for each of the ECQs for submission and certification by an OPM Qualifications Review Board (QRB) in order to be placed in this position. If you are currently serving in a career SES appointment, are eligible for reinstatement into the SES, or have successfully completed an SES Candidate Development Program approved by the Office of Personnel Management (OPM), you will not need to draft the ECQs.

Education
This job does not have an education qualification requirement.

Additional information
Salary for SES positions varies depending on qualifications. The annual salary range is found at the top of this announcement. The selectee for this position may be eligible for annual performance bonuses and performance-based pay adjustments.

Veteran's Preference does not apply to the SES.

How You Will Be Evaluated
We use a multi-step process to evaluate and refer applicants:

1. Minimum requirements: Your application must show that you meet all requirements, including the education and/or experience required for this position. You may be found 'not qualified' if you do not possess the minimum competencies required for the position. If your application is incomplete, we may rate you as ineligible.
2. Rating: A panel of Senior Executives will review your application and evaluate your qualification for this position based on the information in your application. Your application will be rated, based on the extent and quality of your experience, education, and training relevant to the duties of this position. Interviews will be at the discretion of the panel and/or selection official.
3. Referral: If you are among the top qualified candidates, your application will be referred to a selection official for consideration and possible interview.

Background checks and security clearance
Security clearance
Not Required

Drug test required
No

Position sensitivity and risk
Moderate Risk (MR)

Trust determination process
Suitability/Fitness

- Required Documents
  Required Documents
  All applicants are required to submit and/or complete the following documents to be considered for the position:

1. Resume that contains your full name, address and phone number, and does not exceed the five page limit;
2. Cover Letter (optional);

3. Online Assessment Questionnaire. To preview the assessment questionnaire, click here: https://apply.usastaffing.gov/ViewQuestionnaire/10598295

NOTE: THE USAJOBS RESUME TEMPLATE MAY RESULT IN A RESUME BEING LONGER THAN FIVE PAGES. PLEASE VERIFY PAGE LENGTH BEFORE SUBMISSION OF APPLICATION.

Applicants who are currently, or were previously, Federal employees must also submit:

1. An SF-50 showing your current or former civil service status; and
2. Proof of OPM Qualifications Review Board certification (OPM-approved SES Candidate Development Program graduates), if applicable.

NOTE: Documents submitted that are not listed in the Required Documents section of this announcement will not be considered or forwarded to the rating panel or selecting official.

- Benefits
  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.

  http://www.opm.gov/healthcare-insurance/Guide-Me/New-Prospective-Employees/

  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
  How to Apply

The application process used to recruit for this position is the RESUME BASED method. Although applicants cannot address the ECQs or PTQs separately, evidence of each must be clearly demonstrated in the five page resume and throughout the rest of the application package.

To be considered for this position, you must submit a complete application no later than 11:59 PM (Eastern Time) on the closing date of the announcement - 10/16/2019. If you fail to submit a complete application prior to the closing time, the application system will not allow you to finish. Requests for extensions will not be granted, so please begin the application process with enough time to finish before the deadline.

ALL APPLICANTS: You must submit a resume (five-page maximum - resumes that exceed the five-page limit will not be considered). You may also submit an optional cover letter. Separate written narratives addressing the ECQs and PTQs will not be considered.

You must complete the online assessment questions. If your resume does not support the responses in your questionnaire, you may be rated "ineligible." We recommend that your resume emphasize your level of responsibilities, the scope and complexity of the programs managed, and your program accomplishments, including the results of your actions.

Your five page resume should include the following:

1. Job Information (Announcement number and title of job for which you are applying)
2. Personal Information (Full name, mailing address, work and

home phone number and email addresses)
3. Education (College/University name, city and state, major, type and year of degree)
4. Work Experience (Job title (including series and grade, if Federal employment, duties and accomplishments, employer's name and address, start and end dates (month and year), hours per week, and salary)
5. Evidence of experience which addresses the five ECQs and the PTQs.
6. Other qualifications (Job-related training courses (title and year), skills, certifications and licenses, honors, awards, and special accomplishments).

It is important that your resume be complete and thorough. Please be sure to include and address all ECQs and PTQs in your resume. A sample five-page resume that incorporates the ECQs can be found in OPM's Guide to Senior Executive Service Qualifications: https://www.opm.gov/policy-data-oversight/senior-executive-service/reference-materials/guidetosesquals_2012.pdf

Steps to submit a complete application:
1. You must have a USAJobs account and be logged in.
2. Once you are logged in and all of your application materials are ready, click the "Apply" button.
3. You must respond to all application assessment questions, carefully following the instructions provided. To preview the questions, click here:
4. You will then be asked to upload your resume and optional cover letter. Additional documentation not listed in the Required Documents will not be considered.

Agency contact information Laura Cowan Laura Cowan
Address

Office of the Administrator

7500 Security Blvd

Woodlawn, MD 21244

US

Learn more about this agency

Become a part of the Department that touches the lives of every American! At the Department of Health and Human Services you can give back to your community, state, and country by making a difference in the lives of Americans everywhere. Join HHS and help to make our world healthier, safer and better for all Americans.

The Centers for Medicare and Medicaid Services (CMS) works in partnership with the entire health care community to improve quality and efficiency in an evolving health care system and provides leadership in the broader health care marketplace. Our effectiveness depends on the capabilities of a dedicated, professional staff that is committed to supporting these objectives. A career with CMS offers the opportunity to get involved on important national health care issues and be part of a dynamic, fast-paced, and highly visible organization.

Visit our careers page

Learn more about what it's like to work at Centers for Medicare & Medicaid Services, what the agency does, and about the types of careers this agency offers.

https://www.cms.gov//

Next steps

You will receive an email informing you of the receipt of your application. Applicants who are determined to be highly qualified

by the SES rating panel will be referred to the selecting official for further consideration and possible interview, at which time you will be contacted. All applicants will be notified of the outcome of their applications once a final selection is made.

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.

- Equal Employment Opportunity (EEO) for federal employees & job applicants

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 in the workplace or the way things are customarily done that provides an equal employment opportunity to an individual with a disability. Under the Rehabilitation Act of 1973 the Equal Employment Opportunity Commission (EEOC) must provide reasonable accommodations:

- 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.

Legal and regulatory guidance

Chief Medical Officer Aetna Better Health of KS (Medicaid) Job at Aetna in Overland Park, Kansas

Aetna

Overland Park, KS, 66210, USA Full Time

Req ID: 61299BR

Job Description

POSITION SUMMARY

The Sr Director, Clinical Solutions MD (CMO) for Medicaid in Kansas is responsible for leadership of strategic medical management activities and processes which contribute to the performance of the markets and promotes quality of care for our members. These responsibilities include development and implementation of medical programs/policies, enhancing relationships with providers and facilities, plan sponsors and regulatory agencies.

The CMO acts as a key business partner in network development, product design, strategic planning, regulatory compliance and community outreach.

The ideal candidate will have previous Medicaid Managed Care experience having worked with state regulators and executed on strategic initiatives and programs. Strong leadership experience, strategic vision and a proven ability to execute on clinical initiatives are a “must have in this position.

The CMO will act as the “Clinical Leader for Aetna Better Health of Kansas and must be willing to travel throughout the state on an “as needed basis.

The CMO for Aetna Better Health of Kansas will develop, implement, support, and promote Health Services strategies, tactics, policies, and programs that drive the delivery of quality healthcare to establish competitive business advantage for Aetna.

Health Services strategies, policies, and programs are comprised of utilization management, quality management, network management, and clinical coverage and policies.

The CMO is responsible for all clinical activities including proper provision of covered services to members; UM activities, developing clinical practice standards and clinical policies and procedures.

Provide leadership of medical management activities. Develops and

implements medical management programs/policies.

FUNDAMENTAL COMPONENTS

Leads, develops, directs and implements clinical and non-clinical activities that impact health care quality, cost and outcomes.

Direct the utilization review process and oversee the quality of utilization determinations.

Ensure compliance with clinical goals through monitoring care management performance.

Responsible for overall medical policies of the unit to ensure the appropriate and most cost effective medical care is received, and for the day-to-day management of medical management staff.

Responsible for recommending changes and enhancements to current managed care, review guidelines, and clinical criteria based on extensive knowledge of health care delivery systems, utilization methods, reimbursement methods, and treatment protocols.

Develops, implements, and interprets medical policy including medical necessity criteria, clinical practice guidelines, and new technology assessments.

Leads clinical staff in the coordination of quality care.

Provides clinical expertise and business direction in support of medical management programs through participation in clinical team activities.

Acts as lead business and clinical liaison to network providers and facilities to support the effective execution of medical services programs by the clinical teams.

Responsibility for predetermination reviews and reviews of claim

determinations, providing clinical, coding, and reimbursement expertise.

Expands Aetna's medical management programs to address members needs across the continuum of care.

Acts as a champion supporting continuous quality improvement efforts to improve the care and services delivered to all populations covered under KanCare.

Works directly with all other medical officers and department and business unit leads to promote excellence in care and service delivery.

Attracts, retains, measures, coaches and develops the talent to meet Aetna's current/future organizational goals.

Establishes and maintains strong and collaborative community and state governmental relationships.

Fosters an inclusive, engaged, success-oriented and accountable culture and working environment.

Seeks out, introduces and applies innovative ideas to Aetna with input from customers and active involvement in industry, professional, academic and community participation.

BACKGROUND/EXPERIENCE

3 to 5+ years of experience in the health care delivery system, e.g. clinical and health care industry required WITH 3 - 5 years of additional leadership and management experience managed care.
Demonstrated ability to create business strategy to drive competitive advantage and shift direction as market conditions dictate. -
Demonstrated ability to interact successfully with external providers.

LICENSES / CERTIFICATIONS

M.D. or D.O., Board Certification in a recognized specialty including post-graduate direct patient care experience.

Active and current KS state medical license without encumbrances or ability to obtain medical license in KS is a job requirement for this position.

EDUCATION

The highest level of education desired for candidates in this position is a MD or DO

ADDITIONAL JOB INFORMATION

Are you ready to join a company that is changing the face of health care across the nation? Aetna Better Health of Kansas is looking for people like you who value excellence, integrity, caring and innovation. As an employee, you ll join a team dedicated to improving the lives of KanCare members. Our vision incorporates community-based health care that works. We value diversity. Align your career goals with Aetna Better Health of Kansas, and we will support you all the way.

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

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

Together we will empower people to live healthier lives.

Functional Skills:

Clinical / Medical - Concurrent review / discharge planning, Clinical /

Medical - Direct patient care (hospital, private practice), Medical Management - Medical Management - Administration/Management, Medical Management - Medical Management - Case Management, Medical Management - Medical Management - Managed Care/Insurance Clinical Staff

Technology Experience:

Desktop Tool - Microsoft Outlook, Desktop Tool - Microsoft Word, Desktop Tool - TE Microsoft Excel

Required Skills:

Finance - Delivering Profit and Performance, Finance - Profit and Quality Vigilance, General Business - Communicating for Impact

Desired Skills:

Benefits Management - Interacting with Medical Professionals, Benefits Management - Maximizing Healthcare Quality, Leadership - Fostering a Global Perspective

Additional Job Information:

Are you ready to join a company that is changing the face of health careacross the nation? Aetna Better Health of Kansas is looking for people like youwho value excellence, integrity, caring and innovation. As an employee, you lljoin a team dedicated to improving the lives of KanCare members. Our visionincorporates community-based health care that works. We value diversity. Alignyour career goals with Aetna Better Health of Kansas, and we will support youall the way.

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

Together we will empower people to livehealthier lives.

Benefit Eligibility

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

Job Function: Healthcare

Aetna is an Equal Opportunity/Affirmative Action employer. All qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, disability, or protected Veterans status.

University of Utah Health Health Plans Quality Improvement Specialist in Murray, Utah, United States

Source URL: https://employment.utah.edu/murray-ut/health-plans-quality-improvement-specialist/5546C7718AD044E4A95BC2678837F5E2/job/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Overview

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

This position for use in Health Plans Departments only.

This position reports to the University of Utah Health Plans (Health Plans) Quality Improvement Manager and is responsible for quality improvement program design, data collection, analysis and presentation related to our Medicaid, commercial, and Medicare products. The position works closely with University of Utah Health and other hospitals and clinics, physicians, the Utah Medicaid program, and multiple community partners.

Responsibilities

- Act as a facilitator and consultant for Health Plans quality improvement initiatives, providing expert input regarding problem identification and resolution, continuous quality improvement, process mapping and redesign, and regulatory requirements.
- Partner with leadership, providers and staff to design and implement strategies for identified quality improvement opportunities.
- Facilitate communication and collaboration across providers and the continuum. Collaborate with leaders, departments, committees, and individuals to support the Health Plans mission and strategic goals.
- Perform audits, chart review, and prepares reports to assess and improve Health Plan compliance with HEDIS measures, operational goals, State Medicaid, and CMS requirements.
- Review and interpret patient care information, from the medical record and other data sources used to identify quality of care issues. Transforms these facts into actionable information for improvement

work.

- Provides education to the organization regarding quality and patient safety topics, performance improvement, and other regulatory metrics and standards.
- Use data to facilitate change, to develop goals, and determine progress toward relevant evidence-based benchmarks. Review and interpret claims and medical record data, and population management analytics, to develop actionable information to facilitate improvement. Collaborate with the care management team on program design and outcome monitoring.
- Provide technical assistance to providers in quality assessment, monitoring, and improvement. Develop collaborative projects and work with care management teams, a variety of public and private providers, policymakers, and researchers to facilitate improvement in population health.
- Lead staff in identifying, prioritizing, and developing action plans to respond to emerging population and service needs. Lead and/or participate in performance improvement initiatives to identify quality and regulatory trends and plan improvement work.
- Perform internal audits and prepares reports to assess and improve organizational compliance with new or existing quality metrics, standards, operational goals, and/or improvement initiatives.

Knowledge / Skills / Abilities

- Ability to perform the essential functions of the job as outlined above.
- Strong Knowledge of health care quality improvement principles and methods.
- Knowledge of Microsoft Office applications and Epic.
- Knowledge of insurance and managed care operations.
- Knowledge of ICD-9/ICD-10, CPT, HCPC, DRG, Revenue codes, insurance, and managed care principles.
- Data analysis and data presentation skills; ability to identify trends and opportunities for improvement.
- Developing and giving effective presentations to diverse groups.
- Strong leadership, quality improvement, and team facilitation skills.

- Excellent written and verbal communication.
- Ability to adapt to organizational and program changes sufficient to work constructively and to cope with ambiguity and setbacks.
- Excellent human relations and communications skills.
- Demonstrated analytical skill and attention to detail.
- Able to work independently and as part of a highly collaborative team with a minimum of supervision.
- Ability to manage projects, multiple priorities, and meet deadlines.
- Active listening, speaking, critical thinking, service orientation, judgment, and decision making skills.
- Demonstrated leadership skills in planning and directing process improvement initiatives, to ensure the smooth operation of the department.

Qualifications

QualificationsRequired

- **Bachelor's degree in a health care field or equivalency.**
- **Three years clinical or other health care experience.**
- **Obtain CPHQ certification within two years of employment.**

Qualifications (Preferred)

Preferred

- **CPHQ certification.**
- **Master's degree in a healthcare or related field.**
- **Three years leading and/or facilitating quality improvement activities in a health care setting.**
- **Training in Project Management, Lean Six Sigma, Performance Improvement, Facilitation, Human Factors, or Process Mapping.**
- **Emphasis on data analysis and interpretation, intermediate to advanced excel skills, and experience with data presentation/visualization.**
- **Demonstrated proficiency with written and analytical reporting.**

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 object. This position involves sitting most of the time and is not exposed to adverse environmental conditions.**

Physical Requirements

Carrying, Color Determination, Lifting, Listening, Manual Dexterity, Near Vision, Pulling and/or Pushing, Reaching, Sitting, Speaking, Standing, Stooping and Crouching, Walking

Share Refer this job to a friend Interested in this opportunity?

Socialize this job opportunity to a friend, colleague, or family member:

EEO Statement

The University of Utah Health Care is an Affirmative Action/Equal Opportunity employer. Upon request, reasonable accommodations in the application process will be provided to individuals with disabilities. The University of Utah Health Care is committed to diversity in its workforce. Women and minorities are encouraged to apply.

Application FAQs

Requisition Number*36351*

Reg/Temp*Regular*

Employment Type*Full-Time*

Shift*Day*

Work Schedule*M-F 8:00- 5:00*

Location Name*University of Utah Health Plans*

Patient Care?*No*

City*Murray*

State*UT*

Department*UIP CST 01H UUHP CLINICAL OPRN*

Category*Insurance / Health Plans*

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Healthcare Management Solutions Medicaid Compliance Reviewer Job in Fairmont, WV

Source URL: https://www.glassdoor.com/job-listing/medicaid-compliance-reviewer-healthcare-management-solutions-JV_IC1143878_KO0,28_KE29,60.htm?jl=3221441061&utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

Healthcare Management Solutions, LLC (HMS) has an immediate opening for a Medicaid Compliance Reviewer to work in the Fairmont, WV or Columbia, MD office or remote. The Medicaid Compliance Reviewer will conduct in-house reviews that include an assessment of risk and program vulnerabilities and focus on areas that could lead to the loss of Medicaid dollars.

Responsibilities:

• Conduct and participate in focused on-site compliance reviews to determine extent of program integrity compliance under Medicaid requirements by the states.

• Develop and prioritize action plans to ensure timely completion of audit reviews

• Perform research and analysis of data obtained related to issuing coverage for state Medicaid offices

• Document findings related to Compliance Reviews in a clear, cohesive, and precise manner

• Use audit software as necessary for documenting reviews and keeping track of the progress

• Prepare final reports and exhibits to summarize findings

• Identify findings requiring remediation

• Use IT systems provided by CMS for data entry

• Implement correction plans and oversee remediation of the issues through completion

• Create and maintain reports to support contractual and regulatory compliance

• Review and update compliance review protocols when new regulations are released to ensure that they reflect the latest information

Desired Skills & Experience:

• Minimum of four years of internal/external compliance audit experience

• Audit software experience preferred

• An intermediate level of knowledge of Local, State, and Federal laws and regulations pertaining to guidelines from Medicaid, and/or healthcare services

• Knowledge of health care privacy and security and other regulations (HIPPA, ERISA) is a plus

• Significant experience in the health insurance sector and/or specifically related to healthcare compliance, healthcare regulations, healthcare auditing, healthcare risk, and/or fraud investigation

• Strong understanding and commitment to professional auditing standards

• High level attention to detail

• Excellent communication skills

• Time management and self-motivation

• Ability to write detailed reports and other documentation according to the standards of formal business writing

Minimum Education and Training Requirements:

• Bachelor's Degree required in a related field or an equivalent combination of education and experience

• Certified Internal/External Auditor (CIA) certification is a plus

To apply: Please submit a current resume at www.hcmsllc.com by selecting the CAREERS tab located at the top right side of the website. For additional information on this position, please contact the HMS Human Resources Department via email: hr@hcmsllc.com.

Healthcare Management Solutions, LLC has established an Affirmative Action Plan. HMS is deeply committed to the concept and practices associated with equal opportunity and affirmative action in all aspects of employment. HMS makes clear that all applicants will be treated without regard to race, color, sex, religion, national origin, age, disability, genetic information, sexual orientation, or gender identity, or any other protected characteristics under applicable law.

This company does not tolerate unlawful discrimination in its employment practices. We recognize the value of diversity in our workforce, and encourage all qualified candidates to apply. We thank all candidates who choose to apply, however, only those selected for a further interview will be contacted.

EEO/M/F/Vet/Disabled

HMS is an EEO/AA/E-Verify compliant employer.