

Jun Guerra

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SUMMARY

Medicaid program integrity executive with 15 years of progressively responsible experience, including more than nine years leading **multidisciplinary teams** across **fraud, waste, and abuse** investigations, financial and **compliance audits**, provider oversight, claims analytics, risk assessment, and regulatory operations. Directs complex statewide portfolios that protect **public health care funds** while balancing due process, provider relationships, access, and compliance obligations. Sets strategy, performance objectives, budgets, contracts, staffing plans, and investigative priorities for high visibility government health programs. Advises executives, legal counsel, auditors, regulators, and operational partners on credible allegations, financial exposure, corrective action, and policy risk. Builds productive relationships with CMS, Medicaid Fraud Control Units, law enforcement, contractors, providers, and oversight bodies. Prepared to bring disciplined judgment and public service commitment to senior program integrity leadership.

EXPERIENCE

Deputy Director, Medicaid Program Integrity

January 2022 - Present

Sierra Health Financing Agency

Sacramento, CA

Direct statewide Medicaid integrity operations covering investigations, audits, analytics, provider oversight, FWA prevention, budgets, contracts, and executive advisory work.

- Directed statewide Medicaid **investigations**, audits, analytics, and **provider oversight** for multidisciplinary integrity teams.
- Created risk reviews combining claims data, **audit findings**, referrals, provider patterns, and **financial information**.
- Coordinated **CMS**, fraud control, auditors, counsel, managed care partners, and providers on corrective actions.
- Managed budgets, **contracts**, staffing plans, and performance objectives against workload and compliance deadlines.
- Briefed executives and task forces on fraud allegations, payment risk, regulatory exposure, and corrective strategies.
- Represented agency interests during technical forums, interagency meetings, and administrative matters involving public funds.

Chief, Compliance and Investigations

July 2018 - December 2021

Pacific Public Benefits Department

Oakland, CA

Led managers responsible for health program investigations, compliance reviews, audit response, provider monitoring, case standards, and executive reporting.

- Led managers overseeing **investigations**, compliance reviews, audit response, and provider monitoring across health programs.
- Built case procedures linking allegations, evidence, financial impact, referrals, corrective actions, and counsel review.
- Integrated payment data, complaints, audit exceptions, and provider history into defensible risk assessments.
- Negotiated provider resolutions with counsel while preserving records for **administrative proceedings** and enforcement referrals.
- Briefed executives on investigative trends, material cases, constraints, and regulatory changes affecting policy priorities.
- Strengthened coordination with auditors, **law enforcement**, federal contacts, contractors, and health care organizations.

Program Integrity Manager

March 2015 - June 2018

Central Valley Medicaid Services

Fresno, CA

Managed investigators, auditors, and analysts conducting Medicaid provider reviews, payment integrity inquiries, compliance monitoring, referrals, training, and performance reporting.

- Managed investigators, auditors, and analysts conducting Medicaid reviews, payment inquiries, and compliance monitoring.
- Introduced triage using financial exposure, beneficiary impact, allegation credibility, and regulatory risk.
- Reviewed workpapers, investigative reports, claims analyses, and provider responses before escalation.
- Coordinated suspected fraud referrals with government attorneys and investigative partners using complete case records.
- Developed measures for case aging, audit completion, recoveries, referrals, and corrective actions.
- Trained staff on **FWA** indicators, documentation standards, referral practices, and emerging Medicaid risks.

Senior Compliance Analyst

June 2012 - February 2015

Western Health Oversight Commission

San Jose, CA

Conducted complex compliance reviews for publicly funded health care providers, analyzing billing, documentation, contracts, claims, financial records, and corrective actions.

- Conducted compliance reviews of providers, billing records, documentation, contracts, and program requirements.
- Analyzed claims and financial records for duplicate billing, unsupported services, and anomalous utilization.
- Prepared memoranda connecting evidence, regulations, financial findings, and recommended management actions.
- Organized exhibits and analytical methods for administrative cases and counsel questions.
- Facilitated provider conferences on findings and corrective actions with an objective regulatory posture.
- Proposed monitoring changes after identifying recurring control weaknesses across compliance work plans.

Program Compliance Specialist

October 2010 - May 2012

Metro County Health Programs

Long Beach, CA

Performed county health program monitoring, reviewing provider documentation, payments, contracts, policies, billing patterns, case files, and operational controls.

- Monitored provider documentation, payments, contracts, and policies for program exceptions.
- Researched questionable billing and service patterns for senior analyst review.
- Maintained evidence trails, correspondence, analytical notes, and disposition records for audit readiness.
- Produced Excel summaries of payment and utilization trends for focused provider monitoring.
- Coordinated information requests with provider offices and operations teams, escalating material concerns.
- Contributed training materials covering billing integrity, recordkeeping, referrals, and public fund stewardship.

PROJECTS

Statewide Risk Review Framework 📅 2022

Public funds deserve disciplined attention. Built an integrated review model using claims analytics, audit findings, provider patterns, referrals, and financial information to focus investigative resources on emerging Medicaid risks.

Provider Resolution and Referral Model 📅 2021

Trust grows when decisions are clear and defensible. Developed documented pathways connecting allegations, evidence, counsel review, provider response, corrective action, and enforcement referral.

LEADERSHIP & AWARDS

- Steering Committee Member, Government Health Program Integrity Roundtable, supported peer learning across public sector integrity programs.
- Mentor, Public Sector Compliance Leadership Forum, guided emerging managers through practical decisions in investigations and regulatory operations.
- Certified Fraud Examiner, recognized professional preparation in fraud examination, evidence review, and investigative practice.

EDUCATION

Master of Public Administration

2014

California State University, Sacramento GPA: 0

Sacramento, CA

Coursework: Public policy, public budgeting, program evaluation, organizational leadership

Bachelor of Science in Health Administration

2010

California State University, Long Beach GPA: 0

Long Beach, CA

Coursework: Healthcare finance, health policy, compliance management, healthcare operations

CERTIFICATIONS

- Certified Fraud Examiner 📅 2016
- Certified in Healthcare Compliance 📅 2017

TECHNICAL SKILLS

- **Program Integrity:** Medicaid, Fraud Examination, Payment Integrity
- **Investigations:** Case Management, Evidence Review, Allegation Triage
- **Auditing:** Compliance Audits, Financial Audits, Audit Workpapers
- **Analytics:** Claims Analytics, Financial Analysis, Excel
- **Provider Oversight:** Provider Monitoring, Corrective Actions, Resolution
- **Regulatory Compliance:** Regulatory Research, Policy Review, Compliance Reviews
- **Risk Management:** Risk Assessment, Risk Prioritization, Control Review
- **Government Relations:** CMS Coordination, Federal Oversight, Law Enforcement
- **Legal Proceedings:** Administrative Proceedings, Counsel Review, Case Exhibits

- **Management:** Strategic Planning, Budget Management, Performance Management
- **Contract Administration:** Contract Oversight, Staffing Plans, Vendor Coordination
- **Executive Communication:** Executive Briefings, Technical Assistance, Stakeholder Engagement

SKILLS

- Medicaid Program Integrity
- Compliance Audits
- Performance Management
- CMS Coordination
- Fraud, Waste, and Abuse
- Provider Oversight
- Strategic Planning
- Executive Communication
- Regulatory Compliance
- Risk Assessment
- Budget Management
- Administrative Proceedings
- Investigations
- Claims Analytics
- Contract Oversight

PROFESSIONAL AFFILIATIONS

- Government Health Program Integrity Roundtable, Steering Committee Member.
- Public Sector Compliance Leadership Forum, Mentor.

LANGUAGES

- English (Native)
- Spanish (Intermediate)

ADDITIONAL INFORMATION

Work Status : Authorized to work in United States. No sponsorship required.

REFERENCES

AVAILABLE ON REQUEST