consulting | training | free webinars

clay@mostlymedicaid.com | 919-727-9231

Medicaid Jobs Hunter

In this packet....

IlliniCare Health hiring Referral Specialist I in Westmont, IL, US

SourceURL: https://www.linkedin.com/jobs/view/referral-specialist-i-at-illinicare-health-1279133531

Referral Specialist I

IlliniCare HealthWestmont, IL, US

Apply

Assist in monitoring utilization of medical services to assure cost effective use of medical resources through processing prior authorizations.

- Initiate authorization requests for outpatient and inpatient services in accordance with the prior authorization list. Route to appropriate staff when needed.
- Verify eligibility and benefits
- Answer phone queues and process faxes within established standards
- Data enters authorizations into the system.
- Qualifications**:
  Education/Experience: High school diploma or equivalent. 2+ years of customer service experience. Knowledge of medical terminology preferred.
- Centene is an equal opportunity employer that is committed to diversity, and values the ways in which we are different. All qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, disability, veteran status, or other characteristic protected by applicable law._

- **Seniority level**

  Entry level

- **Employment type**

  Full-time

- **Job function**

  Health Care Provider

- **Industries**

  Hospital & Health Care

Pharmacy Provider Liaison at Centene Corporation

SourceURL: https://jobs.centene.com/job/columbus/pharmacy-provider-liaison/17169/11951369

Columbus, Ohio Apply Now Job ID 1141557 Category Health Insurance Operations Organization Buckeye Community Health Plan Schedule Full-time

Description:

Position Purpose: Perform duties to act as a liaison between providers, the health plan and Corporate including investigating and resolving provider physician injectable claims issues. Perform training, orientation and coaching for performance improvement within physician practices. Communicate effectively and partner with all internal departments to ensure members and providers have a positive, successful outcome.

- Serve as primary contact for providers serving as a liaison between the provider and the health plan for all pharmacy concerns
- Conduct monthly face to face meetings with the providers documenting discussions, issues, attendees, and action items researching claims issues on-site and routing to the appropriate party for resolution
- Receive and respond to provider related issues
- Recommend changes in pricing subsystems
- Attend weekly meetings with Case Management to assist where needed with pharmacy or medication concerns
- Educate providers regarding policies and procedures related to pharmacy issues; web site education, and problem solving (liaison responsibilities)
- Perform Provider orientations (includes writing/updating orientation material when necessary)
- Must have a good driving record and the ability to travel

Qualifications:

Education/Experience: Bachelor's degree in Healthcare related field preferred. 3+ years of combined public relations and pharmacy related experience. Knowledge of health care, managed care, Medicare or Medicaid preferred. Claims billing/coding knowledge preferred.

License/Certification: Valid driver's license. CPhT license preferred.

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

MetroPlus Health Plan hiring MLTC Marketing Representative in New York City, NY, US

SourceURL: https://www.linkedin.com/jobs/view/mltc-marketing-representative-at-metroplus-health-plan-1274961526

MLTC Marketing Representative

New York City, NY, US

Marketing Statement

MetroPlus Health Plan provides the highest quality healthcare services to residents of Bronx, Brooklyn, Manhattan, Queens and Staten Island through a comprehensive list of products, including, but not limited to, New York State Medicaid Managed Care, Medicare, Child Health Plus, Exchange, Partnership in Care, MetroPlus Gold, Essential Plan, etc. As a wholly-owned subsidiary of NYC Health + Hospitals, the largest public health system in the United States, MetroPlus' network includes over 27,000 primary care providers, specialists and participating clinics. For more than 30 years, MetroPlus has been committed to building strong relationships with its members and providers to enable New Yorkers to live their healthiest life.

Position Overview

The Managed Long Term Care (MLTC) Marketing Representative provides access to MLTC insurance, by providing education and assistance to long term care recipients. The MLTC Marketing Representative provides education on Managed Long Term Care features and benefits to consumers, providers, and business partners.

Job Description

- Educate and enroll Medicaid eligible for the MetroPlus Managed Long Term Care product.
- Identify eligible Medicaid consumers via Home Care Agencies, Adult Day Care Centers, DME Provider offices, Caregiver Resources Centers, specialty provider offices, HHC Long Term Care Facilities, etc.
- Understand and apply all policies and procedures pertaining to:
- Disclosures and provisions of the various MetroPlus Health Plan products.
- Enrollment and disenrollment for each line of business.
- Remain knowledgeable of services available and utilized by Medicaid consumers eligible for MLTC, i.e., In Home Services for the Elderly Program, Housing Options, Government Benefits, shopping assistance, exercise classes, meals on wheels, etc.
- Responsible for understanding the basic concepts, features, benefits of MetroPlus MLTC product.
- Responsible for selling the services provided by the Plan, such as covered benefits, non-covered benefits, exclusions and exemptions.
- Provide education on Managed Long Term Care features and benefits to consumers, providers, and business partners.
- Responsible for remaining informed of, and adhering to, marketing activity guidelines as set forth by various agencies such as; HRA, DSS, SDOH.
- Responsible for assisting the consumer with the following:
- Selecting a PCP
- Completing required marketing materials and documentation as determined by MetroPlus and various regulatory agencies such as; HRA, DSS, SDOH.
- Completion of enrollment form, required documents and reports i.e. transmittal reports, batch sheets top process an application for a Medicaid consumer eligible for MLTC.
- Follow up on "Leads" and "Referrals" from family members, and caregivers of consumers eligible for enrollment in the MetroPlus MLTC product.
- Responsible for maintaining an adequate supply of marketing materials at times.
- Responsible for meeting marketing enrollment goals as set forth by the Plan.
- Conduct presentations to Home Care Agencies, support groups, caregiver trainings, etc. as well as conduct home visits, and personalized appointments as needed to complete the enrollment process.
- Ensure that promotional activities are conducted to promote the MetroPlus MLTC product, (i.e., placement of signage and brochures in patient waiting areas, conduct outreach calls, participate in events/health fairs and workshops attended by consumers, caregivers, and providers) including evening and weekend hours.
- Work closely with Outreach Representatives, Member Service Representatives, Eligibility Representatives, Utilization Management, and other MetroPlus personnel to resolve member concerns regarding complaints and potential enrollment or disenrollment.
- Establish and sustain beneficial relationships with the Home Care Providers, Caregivers, medical specialist (Occupational/ Physical/Speech/Rehabilitation Therapist), Home Health

Aides, Mental Health and Substance Abuse Providers, social workers, discharge planners and other providers that work with the Medicaid Long Term Care patients.
- Responsible for participation in weekly, bi-weekly, and monthly full staff, team and one-on-one meetings.
- Recognizing and implementing new marketing opportunities.
- Assisting members in accessing health care needs and other services as needed.
- Establish and maintain good working relationships with provider organizations and community organizations where marketing activities are conducted.
- Promoting the Vision, Mission, Values and Goals of MetroPlus Health Plan.
- Conducting and participating in telemarketing/outreach efforts as required.

Minimum Qualifications

- Must have a High School Diploma or GED, College Degree or coursework preferred
- 2-3 years of Sales/Customer Relations experience required
- Managed Long Term Care experience preferred
- Valid NYS Driver's License is a plus

Licensure And/or Certification Required

- New York State Life, Accident and Health Insurance Agent License

Professional Competencies

- Integrity and Trust
- Customer Focus
- Functional/Technical Skills
- Written/Oral Communications

How To Apply

If you wish to apply for this position, please apply online by clicking the "Apply Now" button or forward your resume, noting the above Job ID #, to:

MetroPlus Health Plan
Human Resources Department
160 Water Street 8th Floor
New York, NY 10038
Attn: Recruitment Unit

- ## Seniority level

  Entry level

- ## Employment type

  Full-time

- ## Job function

  MarketingSales

- ## Industries

  Hospital & Health Care

Humana hiring Medical Management Coordinator - Louisiana Medicaid in Metairie, LA

SourceURL: https://www.linkedin.com/jobs/view/medical-management-coordinator-louisiana-medicaid-at-humana-1275319329

Medical Management Coordinator - Louisiana Medicaid

Description

Humana's Medical Management Coordinator leads Medical Management team members to develop and implement medical policy that advances outcomes for plan members in Louisiana. The Medical Management Coordinator actively oversees all levels of medical delivery and uses evidence-based data and analysis to improve outcomes in all areas of care. They will also manage all Medicaid medical management requirements under Louisiana Department of Health (LDH) policies, rules, and contract terms.

Responsibilities

Humana's Medical Management Coordinator leads Medical Management team members to develop and implement medical policy that advances outcomes for plan members in Louisiana. The Medical Management Coordinator actively oversees all levels of medical delivery and uses evidence-based data and analysis to improve outcomes in all areas of care. They will also manage all Medicaid medical management requirements under Louisiana Department of Health (LDH) policies, rules, and contract terms.

Essential Functions And Responsibilities

- Ensure adoption and consistent application of appropriate inpatient and outpatient medical necessity criteria
- Ensure the appropriate concurrent review and discharge planning of inpatient stays is conducted
- Develop, implement, and monitor the provision of care coordination, disease management, and case management functions
- Monitor, analyze, and implement appropriate interventions based on utilization data, including identifying and correcting over- or under-utilization of services
- Oversee prior authorization functions and assure that decisions are made in a timely and consistent manner based on clinical criteria and meet timeliness standards to ensure appropriate Notice of Action is followed including collaboration with the Medical Director to ensure reason for denial, reduction, or termination is specific and clear
- Manage and oversee the Medical Management operations and staff
- Develop and implement departmental policies and procedures in accordance with contract changes and/or updates
- Work collaboratively with all levels of the organization to measure, monitor, and improve performance in all aspects of clinical medical management
- Maintain coordination through all disciplines and organizations, including Humana case management staff, providers, and community resources

- Assist Plan leadership in strategic planning to achieve better plan and enrollee outcomes to ensure adoption of Inter-Reliability Rating (IRR) processes for utilization management (UM)
- Maintain compliance with LDH, Department of Health and Human Services (DHH), and the Centers for Medicare and Medicaid Services (CMS) guidelines and contractual requirements
- less than 10% travel to the Louisiana Market Office's

Required Education, Certification, & Experience Qualifications

- Louisiana-unrestricted licensed Registered Nurse
- Master's degree in health services, healthcare administration, or business administration with a minimum three (3) years of management/supervisory experience OR Bachelor's degree in health services, healthcare administration, or business administration with 7 years of management/supervisory experience in Utilization Management
- Knowledge of Medicaid regulatory requirements, National Committee for Quality Assurance (NCQA) standards, and Medicaid and federal health regulations

Preferred Experience Qualifications

- Five (5) years of previous clinical experience
- Experience working with Medicaid, TANF, and CHIP populations

Scheduled Weekly Hours
40

State of Colorado hiring Medicaid Director, Department of Health Care Policy & Financing in Denver, CO, US

SourceURL: https://www.linkedin.com/jobs/view/medicaid-director-department-of-health-care-policy-financing-at-state-of-colorado-1276469673

Department Information
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 paid holidays, accrual of paid sick and vacation/annual 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
Description of Job
What You'll be Doing

- Acts as the primary contact for the department with the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) and is responsible for the Department's state and federal compliance.
- Attends CMS meetings and regional conference calls, state-based regional and national meetings with other Medicaid Directors to ensure awareness of changing policies.

- Keeps CMS informed of new Department initiatives or policy changes and seeks technical assistance from CMS to improve current programs or to acquire permission and approval to pursue new programs or waivers.
- Manage a multitude of relationships with different partners and stakeholders in order to leverage a complex system environment to bring services to beneficiaries and achieve quality outcomes.
- Leads Department staff, in developing and implementing medical assistance programs including Medicaid, the Children's Health Plan Plus program, and Home and Community Based Services for the older adult and people living with disabilities populations.
- Works with other areas of the Department to develop statistical, data and management information reports to analyze and evaluate the Triple Aim effectiveness and value outcome of all medical assistance programs.
- Acts as Office Director for the Department's Health Programs Office (> 100 staff) responsible for leading management in developing and ensuring staff success of running a health program.
- Reports program results to the Executive Director and makes related recommendations for improvement in policies and procedures that improve Triple Aim quality, member satisfaction and claim trend control.
- Works through the budgeting process to efficiently, thoughtfully and responsibly acquire and manage funds to operate the Medicaid and related medical assistance programs.
- Develops, approves, changes, and recommends program policies, rules and regulations and works with Department staff to develop provider rates.
- Develops communication materials with Department staff to effectively communicate all medical assistance programs and policy changes.
- Interacts with the federal government to develop and negotiate state plan amendments and waivers.
- Assures all medical assistance programs are compliant with State and Federal regulations.
- Recruits and hires qualified, dedicated and diverse staff that reflect the people of Colorado.
- Identifies new and existing staff training needs and works with Department staff to develop related training programs.
- Coordinate and partner closely with member advocate groups, counties, private sector providers, academic research and policy organizations, and publicly funded clinics and hospitals to achieve the Triple Aim and goals of the Department.
- Collaborates with the Executive Director and other senior leadership to represent and advocate for the Department and the Governor before key external stakeholders to include: The Legislature, tribal governments, statewide elected officials, constituent groups, local government, professional associations, businesses, labor organizations, interagency groups, Congress and federal agencies.

Minimum Qualifications

Minimum Qualifications, Substitutions, Conditions of Employment & Appeal Rights

Education And Experience

- Minimum of bachelor's degree in health-related field, management, business, or public administration.
- Master's degree in related field preferred.
- Experience in health care management with specific experience in Medicaid program leadership, public health program leadership.
- Experience in health insurance carrier leadership preferred.
- Experience in health regulations, law and/or program components.
- Knowledge of federal health care programs and related requirements.

This experience MUST be clearly explained in your employment history of the online application.
Substitutions

A combination of professional work experience in health care program management, which provided the same kind, amount and level of knowledge acquired in the required education, may be substituted on a year-for-year basis for the bachelor's degree. A master's degree from an accredited college or university in Public Health, Public Policy, Health Care Administration, or other closely related field may be substituted for the bachelor's degree and one year of general experience.
DEFINITION OF PROFESSIONAL EXPERIENCE: Work that involves exercising discretion, analytical skill, judgment, 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.

Preferred Qualifications

- Experience as a senior member of the leadership team of a medium to large organization in the health care field.
- Experience implementing a strategic plan at an executive leadership level for an organization or division and evaluating the success and impact of the associated initiatives.
- Experience identifying and interpreting data and information relative to market trends as well as program impact against objectives.
- Experience demonstrating effective communication and collaboration with stakeholders and executives to help achieve the strategic goals of an organization.
- Experience overseeing the day-to-day delivery of the programs and services of an organization including operations management, contract negotiation, policy development, strategic initiatives and implementation.

Special Qualifications

- Demonstrated Medicaid program acumen and senior leadership experience.
- Demonstrated ability to implement effective programs and policies that achieve the triple aim - improve patient health, increase patient satisfaction, and control costs.
- Experience as a senior leader in a health care organization, including the management of a large staff.
- Experience in public health, health care or health insurance including senior leadership responsibility for development of successful programs and policies.
- Experience with federal and state reimbursement regulations, health care delivery systems, modern managed care principles, working with government entities on a state and national level.
- Oversight of, and accountability for, the budgeting process for a large department and a significant budget.
- Experience analyzing state and federal statutory changes and rules and directing staff to implement changes affecting Medicaid operations and policy to ensure compliance with both state and federal regulations.

Highly Desirable Competencies

- Exceptional integrity, ethics and transparency.
- Significant fiscal responsibility in a complex organization managing budgets and budget policy alignment.
- Demonstrated ability to build a member-centered organization, acting as a strategic business partner while still performing a regulatory function with an emphasis on adding value through improved customer service.
- Progressive management experience in a private or non-profit health insurance program, government agency, or other related public, private, or non-profit health service organization.

- Extensive knowledge of federal and state medical programs, managed care operations and principles, alternate payment models, health care provider marketplace, state and federal health care reform law and policy.
- Extensive experience with provider, stakeholder, consumer, and client outreach and communication.
- Experience using performance metrics and data to achieve outcomes and attain goals and continuous improvement methods aimed at better outcomes.
- Knowledge of historical context of Colorado State health policy and evolution of federal law impacting low income populations, including Title XIX (Medicaid), Title XXI (CHIP), Title XVIII (Medicare), national health reform, and Colorado's Tribes.
- Experience in health equity, addressing systemic health disparities and collaborating with diverse, vulnerable and underrepresented populations with a commitment to cultural competency that enables effective outcomes and working relationships in cross-cultural situations.
- Ability to respond thoughtfully to questions from the media, speak clearly, responsibly, and thoughtfully at public gatherings, and represent the Department and state government as directed by the Executive Director and as a representative of the Governor.
- Ability to participate in statewide planning efforts to improve the costs and quality of health care services to Coloradoans and determine what policies, programs, and budgets are needed to achieve department goals.
- Experience developing project plans for new initiatives and direct staff to implement projects on time, and on budget.
- Experience interacting with and influencing elected officials, legislative representatives, committees and/or other governmental entities as well as businesses, Tribes, community leaders and other stakeholders and partners.

Conditions of Employment

- All positions at HCPF are security sensitive positions and require individuals undergo a criminal record background check as a condition of employment.
- Significant statewide travel and occasional national travel to various national conventions is a regular part of this position and may involve weekend work and/or overnight and/or extended stays for conferences and meetings. Reliable transportation is necessary.
- Employees who have been disciplinarily terminated, resigned in lieu of disciplinary termination, or negotiated their termination from the State of Colorado must disclose 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.
Supplemental Information
How to Apply (PLEASE READ CAREFULLY)
Applicants are encouraged to submit a resume and cover letter with their application. Please note that ONLY your State of Colorado job application will be reviewed during the initial

screening; if you submit a resume and cover letter, they will be reviewed in later stages of the selection process. Therefore, it is paramount that you clearly describe all of your relevant experience on the application itself. Applications left blank or marked "SEE RESUME" will not be considered.
Your application will be reviewed against the minimum qualifications for the position. If your application demonstrates that you meet the minimum qualifications, you will be invited to the comparative analysis process, which is described below.
Comparative Analysis Process
The comparative analysis process will consist primarily of a review of applications against the minimum and preferred qualifications of this position. Applications will be reviewed in comparison to all others in the applicant pool in order to identify a top group of candidates who may be invited for a final interview. Depending on the size of the applicant pool, additional selection processes may be utilized to identify a top group of candidates. Applicants will be notified of their status via email.
Failure to submit properly completed documents by the closing date or when the required number of applications have been received, as specified in this announcement, will result in your application being rejected.
ADAAA Accommodations: Any person with a disability as defined by the ADA Amendments Act of 2008 (ADAAA) may be provided a reasonable accommodation upon request to enable the person to complete an employment assessment. To request an accommodation, please contact the person listed on this announcement by phone or email at least five business days before the assessment date to allow us to evaluate your request and prepare for the accommodation. You may be asked to provide additional information, including medical documentation, regarding functional limitations and type of accommodation needed. Please ensure that you have this information available well in advance of the assessment date.
~THE STATE OF COLORADO IS AN EQUAL OPPORTUNITY EMPLOYER~
Technical Help
If you experience difficulty in uploading or attaching documents to your online application, call NEOGOV technical support at 877-204-4442 anytime between 6:00 a.m.-6:00 p.m. (Pacific Time).

Mid West Apply hiring Supervisory Health Insurance Specialist with Centers for Medicare & Medicaid Services in Chicago, IL, US

SourceURL: https://www.linkedin.com/jobs/view/supervisory-health-insurance-specialist-with-centers-for-medicare-medicaid-services-at-mid-west-apply-1278645778

The position listed below is not with Mid West Apply but with Centers for Medicare & Medicaid Services

Supervisory Health Insurance Specialist========== Department of Health And Human ServicesCenters for Medicare & Medicaid Services Consortium for Medicare Health Plan OperationsOverview--------- Open & closing dates05/13/2019 to 05/24/2019- ServiceCompetitive- Pay scale & gradeGS 14- Salary$116,040 to $150,856 per year- Appointment typePermanent- Work scheduleFull-TimeLocation--------1 vacancy in the following location:-Chicago, IL 1 vacancy Relocation expenses reimbursedNo Telework eligibleYes as determined by agency policy- Videos---------- Duties------### SummaryThis position is located in the Department of Health &

HumanServices (HHS), Centers for Medicare & Medicaid Services (CMS),Consortium for Medicare Health Plan Operations, Chicago Health PlansBranch.As a Supervisory Health Insurance Specialist, GS-0107-14, you willbe directing staff and overseeing functions of the Regional Office,Central Office, Consortia and groups external to CMS and advisingleadership on Medicare Health Plans (MHP) Operations.Learn more about this agency### Responsibilities- Direct the regional component review of applications.- Assure adequate follow up activities are implemented as needed.- Direct the analysis of new or proposed administrative policy,regulations, or legislation impacting plan operations.- Direct and oversees branch staff.### Travel RequiredOccasional travel - You may be expected to travel up to 20% for thisposition.##### Supervisory statusYes##### Promotion Potential14- #### Job family (Series)0107 Health Insurance Administration- Requirements----------### Conditions of Employment- You must be a U.S. Citizen or National to apply for thisposition.- You will be subject to a background and suitabilityinvestigation.- Time-in-Grade restrictions apply.### Qualifications**ALL QUALIFICATION REQUIREMENTS MUST BE MET BY THE CLOSING DATE OFTHIS ANNOUNCEMENT.****In order to qualify for the** GS-14, you must meet the following:You must demonstrate in your resume at least one year (52 weeks) ofqualifying specialized experience equivalent to the GS-13 gradelevel in the Federal government, obtained in either the private orpublic sector, to include: 1) Serving as a technical advisor on theadministration of Medicare Health Plans (MHP) or managed healthcareprograms; 2) Leading or supervising others through assigning,prioritizing and reviewing work; and 3) Making decisions andrecommendations to improve existing department-wide Medicare HealthPlans program operations.Experience refers to paid and unpaid experience, including volunteerwork 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, andskills and can provide valuable training and experience thattranslates directly to paid employment. You will receive credit forall qualifying experience, including volunteer experience.Click the following link to view the occupational questionnaire:### EducationThis job does not have an education qualification requirement.### Additional information**Bargaining Unit Position:** **NoTour of Duty:** Flexible**Recruitment/Relocation Incentive:** Not Authorized**Financial Disclosure:** Required**The Interagency Career Transition Assistance Plan (ICTAP) andCareer Transition Assistance Plan (CTAP)** provide eligibledisplaced federal employees with selection priority over othercandidates for competitive service vacancies. To be qualified youmust submit the required documentation and be rated well-qualifiedfor this vacancy. Click here for a detailed description of therequired supporting documents. A well-qualified applicant is onewhose knowledge, skills and abilities clearly exceed the minimumqualification requirements of the position. Additional informationabout ICTAP and CTAP eligibility is on OPM's Career TransitionResources website atwww.opm.gov/rif/employee_guides/career_transition.asp.**Additional Forms REQUIRED Prior to Appointment:**- **Optional Form 306, Declaration of Federal Employment and theBackground/Suitability Investigation** - A background andsuitability investigation will be required for all selectees.Appointment will be subject to the successful completion of theinvestigation and favorable adjudication. Failure tosuccessfully meet these requirements may be grounds forappropriate personnel action. In addition, if hired, areinvestigation or supplemental investigation may be required ata later time. If selected, the Optional Form 306 will berequired prior to final job offer. Click here to obtain a copyof the Optional Form 306.- **Form I-9, Employment Verification and the ElectronicEligibility Verification Program** - CMS participates in theElectronic Employment Eligibility Verification Program(E-Verify). E-Verify helps employers determine employmenteligibility of new hires and the validity of their SocialSecurity numbers. If selected, the Form I-9 will be required atthe time of in-processing. Click here for more information aboutE-Verify and to obtain a copy of the Form I-9.- **Standard Form 61, Appointment Affidavits** - If selected, theStandard Form 61 will be required at the time of in-processing.Click here to obtain a copy of the Standard Form 61.**Additional selections** may be made from this announcement forsimilar positions within CMS in the same geographical location. ForCentral Office vacancies, the "same geographical location" includesBaltimore, Maryland; Bethesda, Maryland; and Washington, D.C.If you are unable to apply online or need to fax a document you donot have in electronic form, view the following link for informationregarding an Alternate Application.### How You Will Be EvaluatedYou will be evaluated for this job based on how well you meet thequalifications above.Once the

announcement has closed, your online application, resume,and CMS required documents will be used to determine if you meeteligibility and qualification requirements listed on thisannouncement. If you are found to be among the top qualifiedcandidates, you will be referred to the selecting official foremployment consideration. Please follow all instructions carefully.Errors or omissions may affect your rating.Your qualifications will be evaluated on the following competencies(knowledge, skills, abilities and other characteristics):- Building Coalitions/Communications- Business Acumen- Leading People- Managing Change- Results Driven### Background checks and security clearance##### Security clearanceNot Required##### Drug test requiredNo##### Position sensitivity and riskNoncritical-Sensitive (NCS)/Moderate Risk##### Trust determination processCredentialing, Suitability/Fitness-Required Documents----------**The following documents are REQUIRED:**1. **Resume** **showing relevant experience; cover letteroptional**. Your resume must indicate your citizenship and if youare registered for Selective Service if you are a male born after12/31/59. Your resume must also list your work experience andeducation (if applicable) including the start and end dates(mm/dd/yy) of each employment along with the number of hours workedper week. For work in the Federal service, you must include theseries and grade level for the position(s). Your resume will be usedto validate your responses to the assessment tool(s). For resume andapplication tips visit:2. **CMS Required Documents (e.g., SF-50, DD-214, SF-15, etc.).**Current CMS employees are REQUIRED to submit a copy of their mostrecent Notification of Personnel Action (SF-50) at the time ofapplication. Additional documents may also be required to beconsidered for this vacancy announcement. Click here for a detaileddescription of the required documents. Failure to provide therequired documentation WILL result in an ineligible rating ORnon-consideration.**PLEASE NOTE:** A complete application package includes the onlineapplication, resume, and CMS required documents. Please carefullyreview the full job announcement to include the "Required Documents"and "How to Apply" sections. Failure to submit the onlineapplication, resume and CMS required documents, will result in younot being considered for employment.- Benefits--------A career with the U.S. Government provides employees with acomprehensive benefits package. As a federal employee, you and yourfamily will have access to a range of benefits that are designed tomake your federal career very rewarding. Learn more about federalbenefits.Review our benefitsEligibility for benefits depends on the type of position you holdand whether your position is full-time, part-time, or intermittent.Contact the hiring agency for more information on the specificbenefits offered.- How to Apply----------Your complete application package, as described in the "RequiredDocuments" section, must be received by 11:59 PM ET on 05/24/2019 toreceive consideration.**IN DESCRIBING YOUR WORK EXPERIENCE AND/OR EDUCATION, PLEASE BECLEAR AND SPECIFIC REGARDING YOUR EXPERIENCE OR EDUCATION.**We strongly encourage applicants to utilize the USAJOBS resumebuilder in the creation of resumes. Please ensure **EACH** workhistory includes **ALL** of the following information:- Official Position Title (include series and grade if Federaljob)- Duties (be specific in describing your duties)- Employer's name and address- Supervisor name and phone number- Start and end dates including month, day and year (e.g. June 18,2007 to April 05, 2008)- Full-time or part-time status (include hours worked per week)- Salary**Determining length of general or specialized experience isdependent on the above information and failure to provide ALL ofthis information WILL result in a finding of ineligible.**- To begin, click **Apply** to access the online application. Youwill need to be logged into your USAJOBS account to apply. Ifyou do not have a USAJOBS account, you will need to create onebefore beginning the application.- Follow the prompts to **select your resume and/or othersupporting documents** to be included with your applicationpackage. You will have the opportunity to upload additionaldocuments to include in your application before it is submitted.Your uploaded documents may take several hours to clear thevirus scan process.- After acknowledging you have reviewed your application package,complete the Include Personal Information section as you deemappropriate and **click to continue with the applicationprocess**.- You will be taken to the online application which you mustcomplete in order to apply for the position. Complete the onlineapplication, verify the required documentation is included withyour application package, and submit the application.To verify the status of your application, log into your USAJOBSaccount (all of yourapplications will appear on the Welcome screen. The ApplicationStatus will appear along with the date your application was lastupdated. For information on what each Application Status means,visit: This agency provides reasonable accommodation to applicants withdisabilities. If you need a reasonable

accommodation for any part ofthe application or hiring process, please send an email to...@cms.hhs.gov. The decision to grant reasonableaccommodation will be made on a case-by-case basis.**Commissioned Corps Officers** (including Commissioned Corpsapplicants that are professionally boarded) who are interested inapplying for this position must send their professional resume (notPHS Curriculum Vitae) and cover letter to ...@cms.hhs.govin lieu of applying through this announcement. The cover lettershould specifically explain how you are qualified for this positionand draw specific attention to your resume that demonstrates thesequalifications. In the subject line of your e-mail please includeonly the Job Announcement Number. In the body of your e-mail pleaseinclude your current rank name and serial number. Failure to providethis information may impact your consideration for this position.CMS employees who are currently appointed under Schedule A authorityand are interested in applying for this position must submit theirresume, Schedule A documentation, transcripts (if positive educationrequired or qualifying through education substitution), and coverletter (optional) to ...@cms.hhs.gov. You MUST include theJob Announcement Number in the subject line of the email to receiveconsideration for the position. For additional information regardingSchedule A authority click here.### Agency contact information### Donna Cottman##### Phone000-###-######### Email...@cms.hhs.gov##### AddressConsortium for Medicare Health Plan Operations7500 Security BlvdWoodlawn, MD 21244USLearn more about this agency### Next stepsOnce your online application is submitted, you will receive aconfirmation notification by email. Your application will beevaluated to determine your eligibility and qualifications for theposition. After the evaluation is complete, you will receive anotheremail notification regarding the status of your application.Within 30 business days of the closing date,05/24/2019, you maycheck your status online by logging into your USAJOBS account(We will update your statusafter each key stage in the application process has been completed.- Fair & Transparent----------The Federal hiring process is setup to be fair and transparent.Please read the following guidance.### Equal Employment Opportunity PolicyThe United States Government does not discriminate in employment onthe basis of race, color, religion, sex (including pregnancy andgender identity), national origin, political affiliation, sexualorientation, marital status, disability, genetic information, age,membership in an employee organization, retaliation, parentalstatus, military service, or other non-merit factor.- Equal Employment Opportunity (EEO) for federal employees & jobapplicants### Reasonable Accommodation PolicyFederal agencies must provide reasonable accommodation to applicantswith disabilities where appropriate. Applicants requiring reasonableaccommodation for any part of the application process should followthe instructions in the job opportunity announcement. For any partof the remaining hiring process, applicants should contact thehiring agency directly. Determinations on requests for reasonableaccommodation will be made on a case-by-case basis.A reasonable accommodation is any change to a job, the workenvironment, or the way things are usually done that enables anindividual with a disability to apply for a job, perform job dutiesor receive equal access to job benefits.Under the Rehabilitation Act of 1973, federal agencies must providereasonable accommodations when:- An applicant with a disability needs an accommodation to have anequal opportunity to apply for a job.- An employee with a disability needs an accommodation to performthe essential job duties or to gain access to the workplace.- An employee with a disability needs an accommodation to receiveequal access to benefits, such as details, training, andoffice-sponsored events.You can request a reasonable accommodation at any time during theapplication or hiring process or while on the job. Requests areconsidered on a case-by-case basis.Learn more about disability employment and reasonable accommodationsor how to contact an agency.#### Legal and regulatory guidance- Financial suitability- Social security number request- Privacy Act- Signature and false statements- Selective Service- New employee probationary periodThis job originated on www.usajobs.gov. For the full announcement and toapply, visit www.usajobs.gov/GetJob/ViewDetails/532857400. Only resumessubmitted according to the instructions on the job announcement listedat www.usajobs.gov will be considered. Associated topics: crime scene, detective, fingerprint, inspector, investigate, investigation, investigative, investigator

President, Medicaid Health Plan - NY (PS22253) in New York City, New York, United States

SourceURL: https://antheminc-actuarial.jobs/new-york-city-ny/president-medicaid-health-plan-ny-ps22253/F0E040AB2D194CDAB39835D4D32803C5/job/?utm_campaign=google_jobs_apply&utm_source=google_jobs_apply&utm_medium=organic

President, Medicaid Health Plan - NY (PS22253)

Location: New York City, New York, United States

New

Requisition #: PS22253

Anthem, Inc. (NYSE: ANTM) offers a spectrum of network-based managed-care health benefit plans to large and small employer, individual, Medicaid and Medicare markets, operating through the three segments: Commercial and Specialty Business, Government Business and Other. Through its affiliated health plans, Anthem companies deliver a number of leading health benefit solutions through a broad portfolio of integrated health care plans and related services, along with a wide range of specialty products such as pharmacy, dental, vision and behavior health benefit services.

KEY Anthem, Inc. FACTS

- Founded in 1944
- Headquartered in Indianapolis, Indiana
- Anthem acquired WellPoint Health Networks Inc in 2004 to become the nation's leading health benefits company. At the time of the merger, the parent company originally assumed the name WellPoint, Inc. In December 2014, WellPoint, Inc. changed its corporate name to Anthem, Inc.

N.Y FINANCIAL AND OPERATIONAL HIGHLIGHTS

2018 Revenues: $2.6 B

Growth Over Prior Year: 4.3%

Gross Profit Margin: 64.1%

CULTURE

Mission:

"Improving Lives and Communities. Simplifying Healthcare. Expecting More."

Vision:

Be the most innovative, valuable, and inclusive partner.

Anthem's values:

- Leadership

- Community
- Integrity
- Agility
- Diversity

Anthem is dedicated to helping people more effectively decide how to choose and consume health care and deliver meaningful value by promoting a culture committed to its strategic imperatives: consumer centricity, provider collaboration, managing the total cost of care and offering solutions for enhanced quality of care that is safe and effective.

The President Medicaid Health Plan will have primary responsibility for the fiscal, operational, legislative, regulatory, and human resources objectives/agenda for assigned Medicaid health plan, part of the Medicaid Business Unit of Anthem, Inc.'s Government Business Division (GBD). This position is responsible for aligning strategy to achieve business goals and build a culture of accountability with people who are results driven, innovative and committed to excellence. This translates to the following specific responsibilities:

1. **Leadership** – Must have experience and demonstrate the ability to perform successfully as a leader of: other leaders, teams and cross-functional groups. A successful incumbent will build the depth and operating environment that can achieve annual operating goals and support long-term growth for our business and our associates. Building strong, deep and highly functioning teams is a requirement.

2. **Achieve Annual Operating and business objectives** – Leader must be adept at managing P&L to include revenue, cost management, SG&A and forward-looking product growth opportunities. Plan leader should have actively led or participated in Cost Management, budget building and forecasting and successful premium rate management and renewals. Annual goals focus around:

a. Operating Gain

b. Growth

c. Cost of Care commitments

d. Revenue

e. Meeting or exceeding Quality and accreditation goals

1. **Experience and deep understanding of health plan operations to include:**

a. Health Services and Quality – Oversight and participation in medical management, including hospital census review, medical staffing, seasonality issues, detailed communications with the medical director and nurse leader and monthly accrual analysis. The incumbent should also have experience with Medicaid and/or CMS quality program management and Accreditation process. This should include a working knowledge of Population Health programs that are common to Managed Medicaid.

b. Product growth/Sales and Community Outreach – Oversight and participation in the development of growth strategies and retention initiatives for health plan. Oversee marketing and product growth strategies, business initiatives, school-based, faith-based, community-based and special needs initiatives. Experience in Complex Population administration, working with stakeholders and new program implementation and growth which may include one or more of the following:

I. LTSS – Long-term Services and Supports

II. BH – Program integration across populations and execution as part of overall plan operation.

III. Other complex populations as may apply

c. **Provider Collaboration, Contracting and Service** – Oversight and/or direct participation in relationships with key hospital, large physician practices/clinic and key ancillary providers such as dental and visioncontractual relationships. Drive provider collaboration and engagement in the areas of service and Payment Innovation. Expect the incumbent would have that requisite network experience.

d. **Plan Operations** – Successful health plans have maintain a strong operating team with an ability to establish operating process, remediate service issues, implement new programs and support all areas of ahealth plan to accomplish established business goals. This includes: interfacing with Regional Operations Team, National Service Centers and Shared service operations.

1. **Strategic planning/competency** – Leader must be adept at the development of the health plan's business plan, quarterly reviews, and Business Operating Reviews and course corrections. Oversee resultinghealth plan budgeting and financials, including management of expenses, financial reports delivered to the State, capital budget planning and management. Incumbent must also possess strong strategic thinkingand problem solving skills.

2. **Manage Customer and Regulatory Objectives** – The successful incumbent will have a proven track record of developing and managing key State regulatory and legislative relationships and processes, includingpremium rates, covered populations, eligibility, benefit design, networks, administrative requirements, and new products.

a. Ensure plan maintains "preferred" position for our State customer – Responsible for establishing and leading an environment with the plan and senior leadership team that continually and effectively seeks toengage the state at multiple levels to meet and exceed service and performance goals while also driving innovation and trust.

b. Collaborate with GR (Government Relations) to achieve goals – Work in matrix model with GR officers to offer thought leadership in the political and legislative processes, and direction relative to contract negotiations with the state. Also aspire to create solutions for our state customers that achieve state and plan objectives that may also include new policy and product solutions.

c. Provide leadership to drive optimal consumer experiences – Work in matrix model with regional leaders and shared services partners to address and resolve claims, provider data, customer service needs and enhancements to meet and/or exceed customer service metrics. Also aspire to create solutions for our state customers that achieve state and plan objectives.

1. **Successfully support and operate within the broader organization's Business model** –Incumbent is required to work successfully in a matrix model business environment to include:

a. Work successfully across all lines of business – Market requires collaboration and teamwork with other GBD lines of business.

b. Work across matrix "shared service" business model – This includes Finance, Quality, Operations, Marketing, Health Care Management, HR, IT, Finance, Actuarial, Underwriting, Legal, compliance, Shared Services and National Service Centers.

c. Leverage Anthem Foundation – Strategic understanding of common interests among key constituents.

d. Successful internal and external communications – Liaison with corporate teams and external communications with the State, providers, members, community groups and the media.

1. **Compliance and Risk Management** – Ensure contract and HIPAA compliance, including securing and coordinating resources necessary for such compliance. Certify monthly and

quarterly financial statements,encounter reporting, quality audits, HEDIS/EPSDT and other required regulatory reports. Oversight of risk management program, including fraud and abuse program compliance, and reporting responsibilities.Identify threats to financial assets, reputation, human resources and actively teach risk management to health plan leadership.

2. **Promote Anthem mission and culture** – Demonstrated success in building and leading successful teams with a culture that is committed to execution, collaboration, communication and a positive growth andlearning environment for our associates. The application of regular coaching, timely performance management and active mentoring. Assess and develop bench strength and retain talent in accordance with Plan-llevel retention and development goals. Ensure Sarbanes-Oxley (SOX) compliance and meet other key manager goals and responsibilities as defined by annual Major Job Objectives (MJO).

Reports to

President, Medicaid East Region

Staff

8 direct reports

Office Location

9 Pine St New York , NY 10005

PROFESSIONAL EXPERIENCE/EDUCATION

- Bachelor'sdegree in relevant area of study; Master's degree preferred.
- Experience having led or participated in costmanagement, budget building and forecasting and successful premium ratemanagement and renewals. Annual goals focus around:
- Operating Gain
- Growth
- Cost of Care commitments
- Revenue
- Meeting or exceeding Quality and accreditation
- Experience in Complex Population administration,working with stakeholders and new program implementation.
- Significant network experience (10 plus years)
- A minimum of 15 years' work related experience withinthe government healthcare programs sector with a minimum of 8 years ofexperience in government-sponsored health insurance programs.
- Proven success in influencing executives andmanagers. Display personal agility to work across a wide array ofbusinesses and stakeholders to develop the credibility to achieve results.

OTHER PERSONAL CHARACTERISTICS

- Highly credible leader who, by reputation, will gain thetrust and confidence of the business leaders.

- Setscompelling goals and shows tenacity, resilience, and bias for action andexecution skills in driving towards these goals.
- Actionoriented, hands-on and with demonstrated experience in an innovative,fast-paced, performance-oriented environment.
- Ishighly articulate and when s/he communicates and engenders credibilitywith everyone s/he interacts with, but, in particular, with executives andassociates. Must be able to influence across all levels of theorganization, from staff to the executive level.
- Leadswith a clear, compelling vision of where s/he wants to take their team,and also a view towards supporting the strategic advancement of thedepartment

Anthem, Inc. is ranked as one of America's Most Admired Companies among health insurers by Fortune magazine and is a 2018 DiversityInc magazine Top 50 Company for Diversity. To learn more about our company and apply, please visit us at careers.antheminc.com. An Equal Opportunity Employer/Disability/Veteran.

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

SourceURL: https://www.linkedin.com/jobs/view/health-insurance-specialist-at-centers-for-medicare-medicaid-services-1273910381

Summary

This position is located in the Department of Health & Human Services (HHS), Centers for Medicare & Medicaid Services (CMS), Center for Medicare(CM), Medicare Drug and Health Plan Contract Administration Group (MCAG), Division of Medicare Advantage Operations (DMAO) .

As a Health Insurance Specialist, GS-0107-13, you will coordinate, implement, and monitor the overall operations of the medicare Advantage plans (MA), Medicare Advantage Prescription Drug plans, and other plans.

Responsibilities

  - Ensure initial compliance with Federal requirements by Medicare Advantage, PACE and other Medicare managed care plans from approval of Federal qualification and Medicare contract to, if necessary, qualification revocation and contract termination.
  - Work with CMS ROs to ensure RO (regional offices) compliance with CMS managed health care program initiatives, and a uniform and consistent program and operating policies, systems, and procedures.
  - Serve as liaison to industry trade associations, consultant groups, health plan staff and enrollees, RO staff, State regulators, and Congress.
  - Lead in conducting special studies, work groups, or projects that result in the identification of trends, issues, and/or areas which may indicate that CMS policies, internal operations or instructions need clarification.
- Travel Required
-

- Occasional travel - You may be expected to travel up to 5% of the time for this position.
-
- Supervisory status
-
- No
-
- Promotion Potential
-
  13
- Job family (Series)
- Requirements

  Conditions of Employment
    - You must be a U.S. Citizen or National to apply for this position.
    - You will be subject to a background and suitability investigation.
    - Time-in-Grade restrictions apply.
- **Qualifications**
-
- **ALL QUALIFICATION REQUIREMENTS MUST BE MET WITHIN 30 DAYS OF THE CLOSING DATE OF THIS ANNOUNCEMENT.**
-
- **In order to qualify for the GS-13** , you must meet the following: You must demonstrate in your resume at least one year (52 weeks) of qualifying specialized experience equivalent to the GS-12 grade level in the Federal government, obtained in either the private or public sector, to include: (1) analyzing, evaluating, or reviewing program operations to improve processes and ensure compliance with regulations; (2) analyzing data and making recommendations to management on how to improve processes and operations; AND (3) advising management of needed modifications to regulations and policies.
-
- Experience refers to paid and unpaid experience, including volunteer work done through National Service programs (e.g., Peace Corps, AmeriCorps) and other organizations (e.g., professional; philanthropic; religious; spiritual; community, student, social). Volunteer work helps build critical competencies, knowledge, and skills and can provide valuable training and experience that translates directly to paid employment. You will receive credit for all qualifying experience, including volunteer experience.
-
- **Time-in-Grade:** To be eligible, current Federal employees must have served at least 52 weeks (one year) at the next lower grade level from the position/grade level(s) to which they are applying.
-
- **Click The Following Link To View The Occupational Questionnaire**
-
- Education
-
- This job does not have an education qualification requirement.
-
- Additional information
-
- **Bargaining Unit Position:** Yes
- **Tour of Duty:** Flexible
- **Recruitment/Relocation Incentive:** Not Authorized
- **Financial Disclosure: Not** Required
-
- CMS employees currently participating in 100% Full-Time Telework Program may be eligible to remain in the program. If an employee in this program is selected, the pay will be set in accordance with the locality pay for the applicable duty station. The listed salary range reflects the locality pay assigned to the duty location(s) listed in the vacancy announcement. For more information about pay based on locality, please visit the

-
- **The Interagency Career Transition Assistance Plan (ICTAP) and Career Transition Assistance Plan (CTAP)** provide eligible displaced federal employees with selection priority over other candidates for competitive service vacancies. To be qualified you must submit the required documentation and be rated well-qualified for this vacancy.
-
- **Additional Forms REQUIRED Prior To Appointment**
    - **Optional Form 306, Declaration of Federal Employment and the Background/Suitability Investigation** - A background and suitability investigation will be required for all selectees. Appointment will be subject to the successful completion of the investigation and favorable adjudication. Failure to successfully meet these requirements may be grounds for appropriate personnel action. In addition, if hired, a reinvestigation or supplemental investigation may be required at a later time. If selected, the Optional Form 306 will be required prior to final job offer.
    - **Form I-9, Employment Verification and the Electronic Eligibility Verification Program** - CMS participates in the Electronic Employment Eligibility Verification Program (E-Verify). E-Verify helps employers determine employment eligibility of new hires and the validity of their Social Security numbers. If selected, the Form I-9 will be required at the time of in-processing.
    - **Standard Form 61, Appointment Affidavits** - If selected, the Standard Form 61 will be required at the time of in-processing.
- **Additional selections** may be made from this announcement for similar positions within CMS in the same geographical location. For Central Office vacancies, the "same geographical location" includes Baltimore, Maryland; Bethesda, Maryland; and Washington, D.C.
-
- If you are unable to apply online or need to fax a document you do not have in electronic form, view the following link for information regarding an
-
- How You Will Be Evaluated
-
- You will be evaluated for this job based on how well you meet the qualifications above.
-
- Once the announcement has closed, your online application, resume, and CMS required documents will be used to determine if you meet eligibility and qualification requirements listed on this announcement. If you are found to be among the top qualified candidates, you will be referred to the selecting official for employment consideration. Please follow all instructions carefully. Errors or omissions may affect your rating.
-
  Your qualifications will be evaluated on the following competencies (knowledge, skills, abilities and other characteristics):
    - Health Insurance
    - Oral Communication
    - Project Management
    - Results Driven
- Background checks and security clearance
-
- Security clearance
-
- Drug test required
-
  No
- Required Documents

  The Following Documents Are REQUIRED
- **Resume showing relevant experience; cover letter optional**. Your resume must indicate your citizenship and if you are registered for Selective Service if you are a male born after

12/31/59. Your resume must also list your work experience and education (if applicable) including the start and end dates (mm/dd/yy) of each employment along with the number of hours worked per week. For work in the Federal service, you must include the series and grade level for the position(s). Your resume will be used to validate your responses to the assessment tool(s). For resume and application tips visit:

- **CMS Required Documents (e.g., SF-50, DD-214, SF-15, etc.).** Current CMS employees are REQUIRED to submit a copy of their most recent Notification of Personnel Action (SF-50) at the time of application. Additional documents may also be required to be considered for this vacancy announcement.
  PLEASE NOTE: A complete application package includes the online application, resume, and CMS required documents. Please carefully review the full job announcement to include the "Required Documents" and "How to Apply" sections. Failure to submit the online application, resume and CMS required documents, will result in you not being considered for employment.
- Benefits

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

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

  Your complete application package, as described in the "Required Documents" section, must be received by 11:59 PM ET on 05/31/2019 to receive consideration.

  IN DESCRIBING YOUR WORK EXPERIENCE AND/OR EDUCATION, PLEASE BE CLEAR AND SPECIFIC REGARDING YOUR EXPERIENCE OR EDUCATION.

  Please Ensure EACH Work History Includes ALL Of The Following Information

  We strongly encourage applicants to utilize the USAJOBS resume builder in the creation of resumes.
    - Official Position Title (include series and grade if Federal job)
    - Duties (be specific in describing your duties)
    - Employer's name and address
    - Supervisor name and phone number
    - Start and end dates including month, day and year (e.g. June 18, 2007 to April 05, 2008)
    - Full-time or part-time status (include hours worked per week)
    - Salary
- **Determining length of general or specialized experience is dependent on the above information and failure to provide ALL of this information WILL result in a finding of ineligible.**
    - To begin, click **Apply** to access the online application. You will need to be logged into your USAJOBS account to apply. If you do not have a USAJOBS account, you will need to create one before beginning the application.
    - Follow the prompts to **select your resume and/or other supporting documents** to be included with your application package. You will have the opportunity to upload additional documents to include in your application before it is submitted. Your uploaded documents may take several hours to clear the virus scan process.
    - After acknowledging you have reviewed your application package, complete the Include Personal Information section as you deem appropriate and **click to continue with the application process**.
    - You will be taken to the online application which you must complete in order to apply for the position. Complete the online application, verify the required

documentation is included with your application package, and submit the application.

- To verify the status of your application, log into your USAJOBS account (
-
- This agency provides reasonable accommodation to applicants with disabilities. If you need a reasonable accommodation for any part of the application or hiring process, please send an email to Dana.dessesow@cms.hhs.gov. The decision to grant reasonable accommodation will be made on a case-by-case basis.
-
- **Commissioned Corps Officers** (including Commissioned Corps applicants that are professionally boarded) who are interested in applying for this position must send their professional resume (not PHS Curriculum Vitae) and cover letter to
-
- CMS employees who are currently appointed under Schedule A authority and are interested in applying for this position must submit their resume, Schedule A documentation, transcripts (if positive education required or qualifying through education substitution), and cover letter (optional) to Dana.dessesow@cms.hhs.gov. You MUST include the Job Announcement Number in the subject line of the email to receive consideration for the position. For additional information regarding Schedule A authority
-
- Agency contact information
-
- Dana Dessesow
-
- Phone
-
- Email
-
- Address
-
- Center for Medicare
- 7500 Security Blvd
- Woodlawn, MD 21244
- US
-
- Next steps
-
- Once your online application is submitted, you will receive a confirmation notification by email. Your application will be evaluated to determine your eligibility and qualifications for the position. After the evaluation is complete, you will receive another email notification regarding the status of your application.
-
  Within 30 business days of the closing date,05/31/2019, you may check your status online by logging into your USAJOBS account (
- Fair & Transparent

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

  Equal Employment Opportunity Policy

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

Reasonable Accommodation Policy

Federal agencies must provide reasonable accommodation to applicants with disabilities where appropriate. Applicants requiring reasonable accommodation for any part of the application process should follow the instructions in the job opportunity announcement. For any part of the remaining hiring process, applicants should contact the hiring agency directly. Determinations on requests for reasonable accommodation will be made on a case-by-case basis.

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

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

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

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

Legal and regulatory guidance

This job originated on

Licensed Behavioral Care Advocate Mississippi Medicaid Telecommute Field Based job at UnitedHealth Group

SourceURL: https://job-openings.monster.com/licensed-behavioral-care-advocate-mississippi-medicaid-telecommute-field-based-gulfport-ms-us-unitedhealth-group/208251066

You're looking for something bigger for your career. How about inventing the future of health care? UnitedHealthcare is offering an innovative new standard for care management. We're going beyond counseling services and verified referrals to behavioral health programs integrated across the entire continuum of care. Our growth is fueling the need for highly qualified professionals to join our elite team. Bring your skills and talents to a role where you'll have the opportunity to make an impact on a huge scale. Join us. Take this opportunity to start doing **your life's best work.(sm)**
As a Behavioral Health Care Advocate you will be responsible for case management and utilization review of behavioral health and substance abuse cases. You'll have a direct impact on the lives of our members as you recommend and manage the appropriate level of care throughout the entire treatment plan.
This position is both field-based and telephonic. When not in the field, this will be a telecommute / work from home position. We are looking to fill positions in the following

areas: Meridian, Laurel, South Haven, Natchez, Gulfport/Biloxi, and Jackson metro area.

If you are located within a commutable distance of one of these areas you will have the flexibility to telecommute* as you take on some tough challenges.

What makes your clinical career greater with UnitedHealth Group? You can improve the health of others and help heal the health care system. You will work within an incredible team culture; a clinical and business collaboration that is learning and evolving every day. And, when you contribute, you'll open doors for yourself that simply do not exist in any other organization.
Primary Responsibilities:

- Make patient assessments and determining appropriate levels of care
- Obtain information from providers on outpatient requests for treatment
- Determine if additional clinical treatment sessions are needed
- Manage inpatient and outpatient mental health cases throughout the entire treatment plan
- Administer benefits and review treatment plans
- Coordinate benefits and transitions between various areas of care
- Identify ways to add value to treatment plans and consulting with facility staff or outpatient care providers on those ideas
- Make patient visits to facilities, public places and homes

Required Qualifications:

- Licensed Master's degree in Psychology, Social Work, Counseling or Marriage or Family Counseling, OR Licensed Ph.D., OR an RN with 2 or more years of experience in behavioral health. Licenses must be active and unrestricted in the state of Mississippi
- 2+ years of post - Masters experience in a related mental health environment
- Proficient Microsoft skills (Word, Excel, Outlook)
- Ability to travel within the territory listed for this position
- Access to high speed internet from home / Broadband cable or DSL
- Dedicated workspace from home

Preferred Qualifications:

- Dual diagnosis experience with mental health and substance abuse
- Experience working in an environment that required coordination of benefits and utilization of multiple groups and resources for patients
- Medicaid experience
- Reside in a commutable distance (50 miles or 50 minutes) of the territory listed

Careers with Optum. Here's the idea. We built an entire organization around one giant objective; make the health system work better for everyone. So when it comes to how we use the world's large accumulation of health-related information, or guide health and lifestyle choices or manage pharmacy benefits for millions, our first goal is to leap beyond the status quo and uncover new ways to serve. Optum, part of the UnitedHealth Group family of businesses, brings together some of the greatest minds and most advanced ideas on where health care has to go in order to reach its fullest potential. For you, that means working on high performance teams against sophisticated challenges that matter. Optum, incredible ideas in one incredible company and a singular opportunity to do **your life's best work.(sm)**

*All Telecommuters will be required to adhere to UnitedHealth Group's Telecommuter Policy

Diversity creates a healthier atmosphere: UnitedHealth Group is an Equal Employment Opportunity/Affirmative Action employer and all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, age, national origin, protected veteran status, disability status, sexual orientation, gender identity or expression, marital status, genetic information, or any other characteristic protected by law.

UnitedHealth Group is a drug-free workplace. Candidates are required to pass a drug test before beginning employment.

Job Keywords: Behavioral Health, Mental Health, Case Manager, Care Coordinator, Care Advocate, Mississippi, South Haven, Meridian, Laurel, Gulfport, Biloxi, Jackson, Natchez, MS, Telecommute, Work From Home, Virtual, Nurse, RN, Social Worker, Psychologist, Medicaid

President Medicaid Health Plan Jobs in Woodbridge Township, NJ

SourceURL: https://www.careerbuilder.com/job/J3V8946GK5B93XZ90WP

Full-Time
Other Great Industries
Insurance

Job Description

The President Medicaid Health Plan will have primary responsibility for the fiscal, operational, legislative, regulatory, and human resources objectives/agenda for assigned Medicaid health plan, part of the Medicaid Business Unit of Company, Inc.'s Government Business Division (GBD). This position is responsible for aligning strategy to achieve business goals and build a culture of accountability with people who are results driven, innovative and committed to excellence. This translates to the following specific responsibilities:

1. **Leadership** – Must have experience and demonstrate the ability to perform successfully as a leader of: other leaders, teams and cross-functional groups. A successful incumbent will build the depth and operating environment that can achieve annual operating goals and support long-term growth for our business and our associates. Building strong, deep and highly functioning teams is a requirement.

2. **Achieve Annual Operating and business objectives** – Leader must be adept at managing P&L to include revenue, cost management, SG&A and forward-looking product growth opportunities. Plan leader should have actively led or participated in Cost Management, budget building and forecasting and successful premium rate management and renewals. Annual goals focus around:

- Operating Gain
- Growth
- Cost of Care commitments
- Revenue
- Meeting or exceeding Quality and accreditation goals

3. **Experience and deep understanding of health plan operations to include:**

- Health Services and Quality – Oversight and participation in medical management, including hospital census review, medical staffing, seasonality issues, detailed communications with the medical director and nurse leader and monthly accrual analysis. The incumbent should also have experience with Medicaid and/or CMS quality program management and Accreditation process. This should include a working knowledge of Population Health programs that are common to Managed Medicaid.

- Product growth/Sales and Community Outreach – Oversight and participation in the development of growth strategies and retention initiatives for health plan. Oversee marketing and product growth strategies, business initiatives, school-based, faith-based, community-based and special needs initiatives. Experience in Complex Population administration, working with stakeholders and new program implementation and growth which may include one or more of the following:

I. LTSS – Long-term Services and Supports
II. BH – Program integration across populations and execution as part of overall plan operation.
III. Other complex populations as may apply

- Provider Collaboration, Contracting and Service – Oversight and/or direct participation in relationships with key hospital, large physician practices/clinic and key ancillary providers such as dental and vision contractual relationships. Drive provider collaboration and engagement in the areas of service and Payment Innovation. Expect the incumbent would have that requisite network experience.
- Plan Operations – Successful health plans have maintain a strong operating team with an ability to establish operating process, remediate service issues, implement new programs and support all areas of a health plan to accomplish established business goals. This includes: interfacing with Regional Operations Team, National Service Centers and Shared service operations.

4. **Strategic planning/competency** – Leader must be adept at the development of the health plan's business plan, quarterly reviews, and Business Operating Reviews and course corrections. Oversee resulting health plan budgeting and financials, including management of expenses, financial reports delivered to the State, capital budget planning and management. Incumbent must also possess strong strategic thinking and problem solving skills.

5. **Manage Customer and Regulatory Objectives** – The successful incumbent will have a proven track record of developing and managing key State regulatory and legislative relationships and processes, including premium rates, covered populations, eligibility, benefit design, networks, administrative requirements, and new products.

- Ensure plan maintains "preferred" position for our State customer – Responsible for establishing and leading an environment with the plan and senior leadership team that continually and effectively seeks to engage the state at multiple levels to meet and exceed service and performance goals while also driving innovation and trust.
- Collaborate with GR (Government Relations) to achieve goals – Work in matrix model with GR officers to offer thought leadership in the political and legislative processes, and direction relative to contract negotiations with the state. Also aspire to create solutions for our state customers that achieve state and plan objectives that may also include new policy and product solutions.
- Provide leadership to drive optimal consumer experiences – Work in matrix model with regional leaders and shared services partners to address and resolve claims, provider data, customer service needs and enhancements to meet and/or exceed customer service metrics. Also aspire to create solutions for our state customers that achieve state and plan objectives.

6. **Successfully support and operate within the broader organization's Business model** – Incumbent is required to work successfully in a matrix model business environment to include:

- Work successfully across all lines of business – Market requires collaboration and teamwork with other GBD lines of business.
- Work across matrix "shared service" business model – This includes Finance, Quality, Operations, Marketing, Health Care Management, HR, IT, Finance, Actuarial, Underwriting, Legal, compliance, Shared Services and National Service Centers.
- Leverage Company Foundation – Strategic understanding of common interests among key constituents.

- Successful internal and external communications – Liaison with corporate teams and external communications with the State, providers, members, community groups and the media.

7. **Compliance and Risk Management** – Ensure contract and HIPAA compliance, including securing and coordinating resources necessary for such compliance. Certify monthly and quarterly financial statements, encounter reporting, quality audits, HEDIS/EPSDT and other required regulatory reports. Oversight of risk management program, including fraud and abuse program compliance, and reporting responsibilities. Identify threats to financial assets, reputation, human resources and actively teach risk management to health plan leadership.

8. **Promote Company mission and culture** – Demonstrated success in building and leading successful teams with a culture that is committed to execution, collaboration, communication and a positive growth and learning environment for our associates. The application of regular coaching, timely performance management and active mentoring. Assess and develop bench strength and retain talent in accordance with Plan-level retention and development goals. Ensure Sarbanes-Oxley (SOX) compliance and meet other key manager goals and responsibilities as defined by annual Major Job Objectives (MJO).

KEY RESPONSIBILITIES

1. Build the depth and operating environment that can achieve annual operating goals and support long-term growth for our business and our associates. Keen attention to development of strong, deep and highly functioning teams is a requirement.
2. Achieve annual operating and business objectives through adept P&L management to include revenue, cost management, SG&A and forward-looking product growth opportunities.
3. Oversight and participation in medical management, including hospital census review, medical staffing, seasonality issues, detailed communications with the medical director and nurse leader and monthly accrual analysis.
4. Oversight and participation in the development of growth strategies and retention initiatives for health plan. Oversee marketing and product growth strategies, business initiatives, school-based, faith-based, community-based and special needs initiatives.
5. Oversight and/or direct participation in relationships with key hospital, large physician practices/clinic and key ancillary providers such as dental and vision contractual relationships.
6. Drive provider collaboration and engagement in the areas of service and Payment Innovation.
7. Maintain oversight of a strong operating team with an ability to establish operating process, remediate service issues, implement new programs and support all areas of a health plan to accomplish established business goals, to include interfacing with national service centers and shared service operations.
8. Navigate seismic growth in the state-sponsored business environment and ongoing state fiscal pressures that pose significant challenges to our existing infrastructure to meet demand for revenue capture opportunities with a potential top line business. This includes, dynamic provider environment with rapid consolidation of providers, threats to our unit cost position and access to services for our members, and competitive threats to our business model by emerging provider delivery models.
9. Evaluate changing market conditions and determine necessary changes to our value proposition to meet state needs/requirements, including understanding new financial, business relationship models and contractual agreements required, and evolving our business strategy and capabilities. Develop existing talent to meet changing market conditions and recruit new talent as required.
10. Convince Regional President of required strategic direction to meet health plan goals, including potential investments required. Convince enterprise program leadership to adopt product solution strategies that are beneficial to the plan.

PROFESSIONAL EXPERIENCE/EDUCATION

- Bachelor's degree in relevant area of study; Master's degree preferred.
- Experience having led or participated in cost management, budget building and forecasting and successful premium rate management and renewals. Annual goals focus around:
- Operating Gain
- Growth
- Cost of Care commitments
- Revenue
- Meeting or exceeding Quality and accreditation
- Experience in Complex Population administration, working with stakeholders and new program implementation.
- Significant network experience (10 plus years)
- A minimum of 15 years' work related experience within the government healthcare programs sector with a minimum of 8 years of experience in government-sponsored health insurance programs.
- Proven success in influencing executives and managers. Display personal agility to work across a wide array of businesses and stakeholders to develop the credibility to achieve results.

OTHER PERSONAL CHARACTERISTICS

- Highly credible leader who, by reputation, will gain the trust and confidence of the business leaders.
- Sets compelling goals and shows tenacity, resilience, and bias for action and execution skills in driving towards these goals.
- Action oriented, hands-on and with demonstrated experience in an innovative, fast-paced, performance-oriented environment.
- Is highly articulate and when s/he communicates and engenders credibility with everyone s/he interacts with, but, in particular, with executives and associates. Must be able to influence across all levels of the organization, from staff to the executive level.
- Leads with a clear, compelling vision of where s/he wants to take their team, and also a view towards supporting the strategic advancement of the department