

Position Vacancies
Western Highlands
Local Managing Entity

Western Highlands, the LME covering the Blue Ridge, Rutherford-Polk, and Trend areas, is recruiting for the positions attached. These positions will be posted in the above area programs and will be sent to employees that have been RIF'd from the three area programs since January 1, 2003. At this time, all of the positions, with the exception of the "Close Out Specialist", will be posted internally only. If there are no internal applicants or no highly qualified internal applicants for these positions, recruitment will be opened to external candidates.

To apply, please send a State Application, PD-107 and cover letter to:

Western Highlands LME
c/o Human Resources
Blue Ridge Center
356 Biltmore Avenue
Asheville, NC 28801

Applications must be received by Friday, August 8, 2003

If you have questions, please contact Rhonda McKee

COO - DESCRIPTION OF RESPONSIBILITIES AND DUTIES:

This position supervises, develops and monitors all components of planning and evaluation, access and clinical coordination, provider and community network development, service management, and quality management for the LME. Also serves as supervisor to the Medical Director. Employee directs other managerial, professional, and support staff in the delivery of above components including the planning, budgeting, and organization of same. Has overall responsibility for the quality, adequacy, and responsiveness of the providers and community network.

Work involves providing leadership in setting agency goals and objectives, resolving internal resource allocation and program integration issues, and developing and monitoring the strategic plan.

Responsible for analysis to assure integration of the functions of the LME, measuring outcomes and results. Identifies problem areas and works collaboratively with Board, community and staff to assure goals and objectives of the LME are followed.

Meet regularly with program directors and medical director to review effectiveness of service programs, consult around personnel issues, set objectives for future service development, review financial operations, and provide consultation regarding inter-departmental and inter-organizational relationships.

Represents the LME in national, statewide, regional and local meetings/initiatives as directed by the Chief Executive Officer.

Coordinate responsibilities with Chief Finance Officer and Human Resources Officer and other staff as needed for whom the COO does not have supervisory responsibility. Coordinate efforts with CEO regarding issues arising from contract agencies. Acts on behalf of CEO when CEO is not available, or as otherwise assigned by CEO.

MINIMUM QUALIFICATIONS:

Master's degree in Human Services or related field and minimum of six years in a similar senior leadership position preferably in a governmental and/or MH/SA/DD setting.

SALARY RANGE: \$59,205 – \$105,404 (Grade 83)

CFO – DESCRIPTION OF RESPONSIBILITIES AND DUTIES

The Chief Financial Officer has responsibility for major system functionality at the LME. These major systems include the system of accounting and the chart of accounts structure to include payroll, accounts payable, fixed assets, IPRS, the system of cost centers and the corresponding design of financial reports.

Responsible for development of cost data, the system of services, service codes and definitions and to assure that the LME is in compliance with billing regulations (Medicaid, Medicare, Insurance). Develops and oversees the Reimbursement program of the LME, analyzes data to assure cost effectiveness.

Oversees contract management and reporting requirements to state or federal grant sources.

Database design and the integrity of data in the LME is also under the purview of the Finance Officer. Responsibility includes being involved in all planning for new initiatives and any corresponding computer programming changes or compliance reporting designs. Responsible for the overall effectiveness of the LME's Management Information System, for managing its growth, and for making it more responsive to management of end-user needs.

The activities of the CFO include the following:

- Supervision and direction for staff
- Program planning and design
- Compliance and monitoring of Contracts, Agencies, Programs
- Financial Reporting to and Relations with LME Board
- Consultant and Senior Management Resource to Area Director
 - Serves as needed in consortium efforts, state-wide committees, represents LME at National Meetings

Work involves providing leadership in setting agency goals and objectives; resolving internal resource allocation and program integration issues; establishing program standards. Planning and budgeting responsibilities reflect short and long-range cycles to address program operations and services that are consistent with the state mental health/development disabilities/substance abuse services program goals and community needs assessment

The CFO works to ensure balance between outcome driven decisions and resource driven decisions, implements manage care concepts of the LME, manages expenditures.

Assures full compliance with federal and state fiscal requirements and ensures that contract providers are also held in compliance with all appropriate financial standards. Monitors same.

MINIMUM QUALIFICATIONS:

Master's degree in Accounting or closely related field and minimum of six years administrative experience involving the participation in the planning and management of administrative services with strong emphasis on budgeting. Thorough knowledge of management/accounting principles, techniques, and practices.

SALARY RANGE: \$51,458 – \$91,084 (Grade 80)

DIRECTOR OF CLINICAL ACCESS AND COORDINATION
DESCRIPTION OF RESPONSIBILITIES AND DUTIES

Responsible for the operation of local access system in compliance with uniform portal of entry and exit as defined in the State Plan which consists of four components: screening/triage, assessment, initial authorization and provision of services/treatment.

Responsible for development and monitoring of screening and triage services for an eight-county catchment area. Coordinate and manage points of entry throughout the eight county service area to include the establishment of a 24 hour toll free and walk-in arrangement, which will provide screening, assessment, authorization, consumer choice and service delivery. Oversee qualified providers responsible for clinical screening to determine nature and urgency of situation, determination of target population eligibility, level of care, authorization of initial assessment and treatment services, and facilitation of consumer choice and referral. Create protocols in order for screening staff to determine target and non-target population eligibility.

Develops initial authorization protocols of routine, emergent and crisis situations.

Develop routine for consumers who do not meet target population to be referred to appropriate community resources.

Responsible for developing criteria/tools in which assessments will be conducted to include psychiatric evaluations.

Responsible for development and ongoing process for after hours emergency structure of the eight counties. This will include the accessible toll free number for the provision of screening, brief assessment of problems and safety issues, problem solving, triage for urgency and referral to emergency or crisis stabilization services. Also responsible for the coordination and efficient dispersal of face-to-face staff and tracking of available hospital and crisis stabilization beds. Create system of face-to-face emergency services in order to file involuntary commitments, including evaluations at various emergency rooms, and in-home interventions.

Works with Director of Consumer and Community Relations to assure there is sufficient publicity for consumers and the general public about how to access the system.

Develop and monitor the policy that governs formal procedures to assure that individuals are not inappropriately denied access during the initial screening, assessment or referral process. This includes assuring proper documentation is reviewed and tracked. Triage decisions will be subject to review for appropriateness

Work with providers to develop procedures and systems to facilitate the rapid transfer of assessment and other information.

Responsible for the monitoring of inpatient beds (Broughton) by receipt of monthly reports from the Division on bed day utilization vs. authorized number of these days for adult crisis unit, adult long term unit, geriatric unit and adolescent unit. This position will be responsible for the development of the system to authorize inpatient admissions and length of stay. Assures that UM service authorization process is being followed for managing bed days.

Develop tools to assure consumers are fully aware of service provider options.

Monitor referral patterns, promptness of response, and all aspects of screening and assessment to determine compliance, with best practices, appropriate access to routine, urgent and emergent services.

Work with MIS to assess compliance of electronic capabilities of providers and to develop system to electronically forward information from the consumer to a provider.

Responsible for determining number and locations of entry points and types of practitioners and programs sufficient to allow timely consumer access (working with Provider Network Director). Studies statistics reflecting need for 30 minute/mile standard and makes improvements to assure compliance.

Works with community to assure that crisis stabilization and acute inpatient services are available in sufficient quantity according to needs assessment.

MINIMUM QUALIFICATIONS:

Master's degree in human services field and at least five years of experience in areas above. License required where applicable.

SALARY RANGE: \$42,547 – \$75,212 (Grade 76)

DIRECTOR OF COMMUNITY AND CONSUMER RELATIONS
DESCRIPTION OF RESPONSIBILITIES AND DUTIES

Coordinate and implement all client rights activities to ensure compliance with client rights rules and regulations from the Division of MH/DD/SAS. Develop and recommend policies, procedures and revisions regarding Client Rights. Monitors providers to ensure that regulations, policies and procedures are practiced and enforced. Assures proper training to providers in order to assure compliance

Oversees LME Client Rights Committee of the Blue Ridge Area Authority. Responsible for arranging training to all committee members regarding policies and procedures pertaining to client rights.

Ensure compliance with all applicable rules and regulations for client rights through reviews and analyzing information related to program objectives, strategies and existing delivery systems in order to develop policies and procedures.

Assures that all client grievances appealed beyond the provider level are responded to by overseeing that grievances are investigated and that the situation has been evaluated through discussions with staff and reviewing the medical record. Strive to resolve the grievance to result in client satisfaction.

Recommend necessary program and/or policy changes or corrective action and follow-up to see that changes are implemented. Direct interface with consumers, family members, administrative staff, direct care staff and external advocates may be required.

Responsible for assuring that the appropriate personnel are contacted from the Division of MH/DD/SAS for Medicaid appeals.

Assures that grievances and appeals are processed satisfactorily, and quarterly summaries for the Client Rights Committee and yearly summary for the Board as part of the Client Rights annual Report are prepared, as well as, reports for the Division, as necessary.

Ensures the rights of consumers are being protected, provide a response system for consumer complaints and appeals. Develop and monitor customer service systems.

Analyzes and makes recommendations concerning patterns and trends of consumer complaints and grievances.

Serves as advisor regarding any client rights issues.

Supervises HIPAA Officer who provides technical assistance, resources and training on privacy issues for LME and provider network; and who also develops policies and procedures and assures HIPAA regulations are met.

Oversees staff for the Consumer and Family Advisory Committee (CFAC) to promote active participation of members of the community. Provides technical assistance and consultation to CFAC and monitors the efforts and achievements of the CFAC to ensure their empowerment to perform their roles and responsibilities.

Responsible for leadership in efforts to increase consumer input and involvement in LME policies and decisions.

Oversees all public contacts with media. Attends public forums and meetings to collaborate and identify community needs.

Responsible for all LME universal prevention activities.

Responsible for liaison with Children's Collaboratives, and other community advocacy and planning organizations.

Responsible for public relations for the LME in the capacity to include education of the public and consumers on the role of the LME and the systems for obtaining services. Designs educational materials and acts as liaison with all media.

Oversees LME reception function. Oversees development of all LME printed materials and electronic media, including LME website.

MINIMUM QUALIFICATIONS:

This position requires a Bachelor's Degree in Administration, Business or related field and a minimum of five years experience at the professional level in areas above.

SALARY RANGE: \$32,290 – \$56,548 (Grade 70)

MEDICAL DIRECTOR
DESCRIPTION OF RESPONSIBILITIES AND DUTIES

This position functions as liaison to medical community to promote the development of appropriate community capacity for serving consumers in the psychiatric and primary care sectors.

Consults with Community and Consumer Relations regarding appeals and complaints regarding availability and quality of psychiatric services.

Serves as advisor to Utilization Management regarding medical aspects of complex service plans as well as authorization criteria and protocols for medical services.

Advises Quality Management regarding criteria for evaluating the adequacy of medical services on an ongoing basis.

Consults to Access and Clinical Coordination to promote community-based services as alternative to hospitalization and to manage use of Broughton Hospital and the Julian Keith ADATC.

MINIMUM QUALIFICATIONS:

Graduation from an accredited school of medicine and completion of residency or specialty training in the field of psychiatry. Eligible for licensure to practice medicine in North Carolina.

SALARY RANGE: \$91,084 - \$163,151 (Grade 92)

DIRECTOR OF PROVIDER & COMMUNITY NETWORK DEVELOPMENT
DESCRIPTION OF RESPONSIBILITIES AND DUTIES

Responsible for the development of criteria by which providers will be included in the network. Criteria will be established for both individual providers and for specialty provider organizations who may provide a variety of services. Develop and implement methods of explaining the necessary array of services for target and non-target populations to providers through meetings and conferences. Interface with Access, Utilization Management and Quality Management regarding treatment protocols and how to disseminate information to providers.

Develop and implement methods to recruit and retain providers for the LME.

Coordinate and make recommendations for the Request for Proposal (RFP) process for services that require sole providers. Develop mechanisms for the preparation and sending out Requests for Proposals to providers. Once developed, continue to analyze ability of current capacity to meet service needs. Create and maintain a database of all existing providers' services in the LME.

Responsible for contract development with providers to include programmatic as well as financial negotiations. Assure that provider staff has appropriate credentials/competencies, the providers' facilities are licensed and accredited and that other standards and mandates are met.

Development of a Memorandum of Agreement for directly enrolled providers.

Provide technical assistance regarding documentation, funding and service delivery. Develop a system to ensure that qualified providers receive timely and accurate information by promoting and developing, in collaboration with Information Services, the most efficient means of communication with providers.

Interface with Quality Management and Services Management regarding medical records issues with providers.

Provide mechanism for addressing complaints/grievances with provider agencies, as well as conflict of interest issues. Monitor provision of services and corrective action needed.

Develop and implement provider training programs with the assistance of other LME staff.

Oversee self-determination initiatives.

In collaboration with community groups and agencies, promote the development of supports and services not reimbursed by the LME. These include non-paid supports and services provided by families, friends, volunteers faith-based and other community organizations, as well as, those financially supported by other organizations. Develop and promote such supports and services for both target and non-target populations.

MINIMUM QUALIFICATIONS:

This position requires a Master's degree in Human Services or related field and a minimum of five years experience in areas above. License required where applicable.

SALARY RANGE: \$42,547 – \$75,212 (Grade 76)

DIRECTOR OF SERVICES MANAGEMENT
DESCRIPTION OF RESPONSIBILITIES AND DUTIES

Create, implement and maintain a utilization management system for services provided through the LME to assure that each consumer receives the most appropriate service in the necessary amount and in the appropriate location. Establish system based on medical necessity and level of care criteria and diagnostic treatment guidelines/protocols as promulgated by DMH and the LME.

Develops guidelines and protocols for authorization and re-authorization of services. Tracks authorizations and studies trends. Reviews service definitions and state guidelines for implications based on Utilization Management experience, makes recommendation regarding clinical protocols and authorization criteria.

Assures consumers receive authorizations in a professional, timely, cost effective manner.

Responsible for overseeing reviews of clinical documentation submitted by providers in order to approve or deny payment of services rendered. Develop system of notification to providers.

Oversees the performance of qualitative record reviews. Responsible for studies on relative cost of all treatments and funding sources prior to service authorization.

Designs and implements processes to promote cost-effective, well coordinated services for consumers.

Develop, refine and study best practices. Assures that the highest standards of treatment and support are understood and practiced in all service settings and that consumers are receiving accessibility to medically-necessary services throughout the service delivery system in a manner that promotes clinical excellence and consumer choice. Reviews results of studies and communicates results to Management Team. Reviews and investigates issues and recommends changes in policy, procedure and protocol to meet highest standards of care. Analyze service needs/array and make recommendations regarding development of new programs. Coordinates continuous review of standards in best practice and makes recommendations. Reviews clinical records and other data to determine standards of practice are implemented through Utilization Management decisions.

Communicates with care managers around ongoing development and implementation of person-centered plan.

Develops operating procedures including second level review, appeals and client notification.

Will accurately collect, analyze, interpret and record a wide range of clinical and fiscal information. Conducts ongoing utilization review activities and produces relevant reports to monitor usage of services across all service populations.

Consults with Medical Director or Director of Clinical Access and Coordination regarding complex authorization decisions.

Provides supervision to clinical specialists who authorize complex service plans and to support staff who apply pre-determined authorizations packages to routine cases and enter authorization data.

Oversees telephonic and mail communication with consumers to ensure appropriate care coordination.

MINIMUM QUALIFICATIONS:

Master's degree in Human Services and five years of experience in areas above. License required where applicable.

SALARY RANGE: \$42,547 - \$75,212 (Grade 76)

DIRECTOR OF QUALITY MANAGEMENT
DESCRIPTION OF RESPONSIBILITIES AND DUTIES

Responsible for the development, implementation, oversight and administration of the LME Quality Improvement Plan and the Quality Improvement Annual Report. Work closely with management and staff to insure program design meets the requirements of all quality management processes. Identify, evaluate and make recommendations regarding service delivery, quality and compliance issues. Integrates data collection and assessments with client care to identify compliance and service delivery issues. Makes recommendation concerning issues that need corrective action

Plans and establishes realistic goals for the operation of client records throughout the provider network. Develops and implements techniques for quality record keeping systems, record reviews, various audits and release of information. Serves as liaison with MIS/Providers for electronic medical records.

Reviews and/or develops program specific operating systems and procedures. Provide training, consultation, evaluation and quality control for provider network and LME staff on an ongoing basis. Introduces and interprets changes and/or new policies and procedures that affect client records. Through consultation, continuously confers with the Division of MH/DD/SAS regarding record issues. Provide training as needed on medical records rules and regulations. Monitors effectiveness of medical records reviews. Review and analyze review reports to identify problem areas.

Identify any systems issues pertaining to records and initiate new/revised policies and procedure and/or corrective action to resolve the issues. Develops system for audits and interprets resulting data and takes action as necessary.

Reviews trends in access to care, consumer outcomes and consumer satisfaction and makes needed recommendations to appropriate areas to meet the goals, objectives of the LME and the strategic plan. Discerns positive and negative trends from raw data and analyzes information against benchmarks.

Oversees privileging and credentialing of all providers. Serves as liaison with State Division of MH/DD/SAS on issues related to changes in privileging, credentialing and core competencies of providers. Develops process and polices for the functions, process, purpose and requirements of privileging and credentialing, as well as systems of assurance of proper monitoring and review.

Responsible for coordination of accreditation and licensure processes of provider panel to assure accreditation/licensures are current, corrective actions are processed and regulatory standards are followed. Serves as coordinator and liaison in cases of national/state accreditation's.

Oversees research and qualitative and quantitative data collection for all aspects of information gathering for the LME service area.

Research and monitor State and Federal Policies to assure compliance with all reporting requirements. Oversee reporting for all services and supports.

Identify gaps in services utilizing community needs assessments and service capacity analyses to assure the service array is culturally diverse, competent to treat co-occurring disorders, dedicated to delivering consumer-directed supports and in compliance with all federal/state guidelines.

Create methods for monitoring best practices.

Plans and collects data for the purpose of assuring the initial and ongoing strategic plan meets goal, and objectives.

Generate reports to monitor consumer outcomes, access, penetration rate, timeliness of receipt of service, quality and continuity of care.

Responsible for creating reports to the Division and annual review of service delivery plans

Analyzes trends in complaints, appeals and incident reports.

Consults with all LME departments regarding research and data collection needs.

MINIMUM QUALIFICATIONS:

Master's degree in Human Services or public administration or related field and two years of administrative or consultative experience in areas above.

SALARY RANGE: \$35,398 - \$62,164 (Grade 72)

ACCOUNTANT - DESCRIPTION OF RESPONSIBILITIES AND DUTIES

Responsible for the management, supervision and operations of the Accounting Department within the Business Office. Directs day-to-day financial operations for all accounting activities for the LME. Directly supervises the work of Accounting Technicians. Serves as advanced technical advisor, problem-solver, and decision-maker. Coordinates the daily work priorities and approves the work of the accounting department staff.

Works with CFO to develop long-range goals for the Business Office, creates the operating budget and coordinates accounting functions in order to achieve efficient, effective and consistent management practices.

Responsible for coordinating, processing and reviewing the fiscal year-end annual financial and compliance audit. Prepares audit bid proposal requests and interviews with prospective auditors. Serves as direct liaison between auditors and staff, coordinating and scheduling the work of others. Responsible for answering audit questions or referring auditors to the most qualified staff about a particular subject. Reviews and proofreads the final audit draft before submission to the Board of Directors and Local Government Commission. Works directly with CPA firm contracted to perform agreed upon procedures for sub-recipient monitoring (affiliate agencies receiving financial assistance).

Oversees the preparation of monthly financial statements, accounts payable system, requisitions, follow-up for purchase orders in addition to developing the AP system, processing of invoices and cash disbursements, annual cost finding, responsible for oversight of all report generation. Directs and supervises accounts receivable for governmental and other miscellaneous revenues. Provides interface with the Division on MH/DD/SAS concerning governmental revenues, specialized billings and special grants. Provides advanced technical support to programs with programmatic billing issues. Reviews, analyzes and interprets cash flow projections. Approves procedures for processing new revenue sources placing emphasis on strong internal controls and policies. Approves daily non-client revenue items for subsequent data entry. Oversees Medicaid fee for service.

Supervises, directs, and approves daily general accounting work in the department. Duties of the staff include reviewing and analyzing balance sheet accounts for main operations, preparing journal entries when necessary. Reconcile bank accounts each month. Prepares semi-annual cash reports for the Local Government commission. Maintains the subsidiary ledger for supported-housing loans and reconciles to the control account. Maintains records on all property subject to NC escheat laws and prepares the annual report. Processes all electronic wire transactions between various cash accounts and writes the journal entries recording these transactions. Reviews the status of the journals and generates reports to correct any journal errors. Provides training for accounting policies and procedures. Update and maintain the accounting policies and procedures manual. Reconciles cash for main bank account and prepares cash reports each month for distribution to management for analyzing and review. Maintains and updates the chart of accounts revenue and expenditure definitions.

Prepares, analyzes and submits the financial information required by the Division.

Responsible for monitoring, updating, and creating strong internal controls for the accounting department. This includes maintaining a high level of continuing education in governmental accounting in order to implement recent changes in accounting standards and to improve internal controls.

Responsible for filing the quarterly payroll reports with the IRS, NC Department of Revenue and the Employment Security Commission. In addition, responsible for processing the year-end 1099's and electronic transmission to the IRS. Responsible for all electronic funds transmissions to the IRS and the North Carolina Department of Revenue for all payroll taxes.

Responsible for the maintenance of the fixed asset records for each program where duties include an annual physical inventory of capital assets, reconciliation of capital expenditures.

Responsible for opening and closing accounting periods. Creates new account numbers for the chart of accounts.

Special projects as assigned by the Chief Financial Officer and Chief Executive Director.

MINIMUM QUALIFICATIONS:

Graduation from a four-year college or university with a major in accounting, and at least one year accounting/auditing experience in the preparation of interpretive or analytical accounting/financial statements and reports. OR a four year degree in business administration or other field with at least 12 semester hours in accounting and two years of experience as specified above. Prefer CPA. Knowledge of accounting principles and practices. Knowledge of established governmental and departmental budgeting and accounting practices and procedures. Ability to understand, interpret, and apply laws and regulations governing the maintenance of financial records. Ability to prepare fiscal reports and analyses and financial statements.

SALARY RANGE: \$33,843 – 59,205 (Grade 71)

REIMBURSEMENT OFFICER
DESCRIPTION OF RESPONSIBILITIES AND DUTIES

Responsible for oversight of support staff for billing services to Medicaid, Medicare, and other Third Party Sources, processing claims for the Managed Care Organization and overseeing through billing and reporting to Medicaid, billing and applying payments for various payors including CAP Medicaid, NC Health Choice, and other miscellaneous sources. Other billings and volume of service reports and adjustments are run monthly and rebills, such as for denials and secondary payors are processed throughout the month. Payments are posted open item to specific service events. Billings and payment applications must be monitored, analysis of payment and denial patterns must be performed, and development of new payors and new service types must be researched and implemented by the supervisor. Technical areas requiring the attention of a supervisor include billing program specifications, service coding, recode tables, authorized service tables, rate schedules, event rules, authorizations, and contractual agreements for each payor or service provider under the Managed Care Unit. Reimbursement policies, must be reviewed and updated on a regular basis

Responsible for development of new payors and service types and for instituting billing system changes to respond to programmatic changes, payer policy and/or industry changes (e.g.: CPT-billing for Medicaid, IPRS, HIPAA). Activities include researching and qualifying services for reimbursement, and serving as liaison to payor contacts and State officials. Includes serving on the Service Code and Review Committee, and participating in liaison meetings with other Business Office Units (IS, Accounting) or with other programs' management teams and office support staffs. Review and technical support of computer based aspects such as billing specifications, electronic billing, and other interfaces including recode tables, authorized service tables, and service activity master to ensure that billing and reporting systems' output are consistent with Center and payor policies. Coordinates indicated changes to the billing systems and computer applications and monitors progress of implemented initiatives. Works in conjunction with IS staff on the continued development efforts, CMHC software enhancements, and implementation of the Managed Care software.

Analysis and Reporting of Third Party Billing and Payment Activity - Reports on specialized third party billing and payment activity. Performs analysis of payment/denial patterns by various payors and appropriate follow-up with program directors and payors. Includes reports, presentations, research and advocacy to the Finance Officer and/or appropriate Program Directors or clinical liaisons, as well as implementing improvements to billing efforts and systems.

Updates reimbursement procedures and policies on a regular Recommends changes to the Service Activity Master, Service Code Definitions and Crosswalks for billing and reporting based on examination of Clinical Practice, current policy, and payer requirements, and adopted reimbursement rates.

Monitors/approves refunds and appropriate accounting entries to record them. All refunds involving specialized third party payments will be submitted to this supervisor for review and approval. All write-offs of uncollectible third party amounts will also be submitted. Problem accounts will also be reviewed. In each of these instances the supervisor will have to access the account in the MIS system as well as related client eligibility, service activity master, and control file information. Review of the client's third party billing file and recognition of specific payor knowledge will also be used to prove and balance the account. Knowledge of inter-related LME MIS components will be used to perform or monitor corrections, write-offs, and refunds.

Training Coordination - Position is responsible for ensuring the provision of adequate in-house training for Reimbursement and other support staff in such areas as reimbursement fundamentals and procedures and computer applications. Position identifies or solicits specific areas where training is needed, organizes training schedules, coordinates the staff responsible for training, conducts training, and evaluates periodically for effectiveness.

Billing Systems Compliance - Ensures the accurate billing, claims processing, and reporting of Events in the MCO and MIS Systems. Compliance and Quality Assurance activities include monitoring service and billing activities, identifying recurring patterns that may indicate areas of attention, conducting audits of charts and billing records, and working with staff both in training and in quality assurance and compliance activities in conjunction with the Center's Quality Assurance and Billing Compliance Programs. Provides Business Office support during Program Audits by Division of Mental Health, DMA, or other third-party payor.

Customer Services Supervision - Position manages the MCO Unit, responding to provider or clinical requests for appeal of denied services or for reconsideration. Facilitates regular workgroup meetings to ensure coordination of clinical and business components. Position also supervises all first and third party billing, responding to client or third party inquiries, requests for information, and billing complaints. Position researches, problem-solves, and communicates response to appropriate individuals or parties.

MINIMUM QUALIFICATIONS:

Four-year college or university degree in Accounting, Business, or related field. College level courses in accounting desirable.

Knowledge of accounting, third party reimbursement and managed care practices. Knowledge of established governmental and departmental budgeting and accounting practices and procedures. Use of computer systems and software, and the ability to use current financial and reporting tools (PC applications, CMHC report writers) effectively. Knowledge of general office practices, and skill in management/ supervisory experience. Strong oral and written communications skills, including the ability to prepare memos and reports for Center management. Ability to coordinate several projects, tasks and responsibilities with other staff effectively.

SALARY RANGE: \$32,290 – 56,548 (Grade 70)

MIS DIRECTOR - DESCRIPTION OF RESPONSIBILITIES AND DUTIES

This position provides the infrastructure supports for the full spectrum of clinical, billing, financial management, IPRS and communication needs for the LME. Oversees system to meet standards for technical architecture, data privacy, security and electronic transactions and to be fully compliant with Federal HIPPA requirements.

Planning and Design, Overall Direction - Responsible for management of information systems throughout the LME. Activities include implementation of new programs/applications and coordinating the appropriate corresponding training, directing the development/programming efforts of staff in meeting the necessary changes or updates to various applications, and helping to plan for brand-new applications. The incumbent directs the deployment of technical resources in repairs, installations of new equipment and major upgrades of software or hardware.

Responsible for serving on man committees to include Utilization Analysis and MIS. Responsible for strategic planning for the expansion of the Unix system, network and free-standing PCs in the various programs. Serves as consultant in the purchase of hardware and software for program use. This position, under the general guidance of the Chief Finance Officer, is responsible for the Information Systems/Computerization portion of the LME Business Plan.

Responsible for analyzing new technologies and recommending changes as needed in order to take advantage of new products in this fast-changing industry.

Directs and supervises the activities of MIS staff.

Computer System Management - Supervises the day-to-day operation of Altos 17000 computer running SCO, UNIX and various applications involving the CMHC/MIS. Performs or monitors the performance of regular maintenance on the system, including tape back-ups, cleaning, file clean-up, wiring, attachment of new peripherals. Also, trouble-shoots and problem-solves issues with any peripheral equipment, evaluates repair options, initiates calls/consults with vendor support line as appropriate. Responsible for installation of software and operating system upgrades and testing of each. System was upgraded to IBM RS6000 in December 1996.

PC Support - Responsible for implementing a center-wide support system for the purchase, set-up, and trouble-shooting for Personal Computers in the various programs. Consultation on software set-up, application and use as appropriate. Problem-solving for printer share-ware, disk utilization, and hardware errors. Development and implementation of PC network.

Network Management - Management of mainframe implementation of e-mail, mainframe side of SIPS (State computer) access, user/password control, and integration with PC network. Continuous research and evaluation of new technologies and how they will effect/benefit our behavioral health environment.

Special Projects and Other - Systems Analysis: Special projects as assigned by Chief Financial Officer in area of Computer Systems Analysis and Quality Control.

MINIMUM QUALIFICATIONS:

Four year college degree in Computer Science or Computer Information Systems or related degree, with at least three years of information systems management experience.

Additional experience with Unix Systems, Local Area Networks (LAN), Wide Area Networks (WAN), and telecommunication equipment/standards very helpful. Work experience in Health Care or Local Government

would also be useful. Knowledge of the use and capabilities of manual and electronic information systems in gathering, storage, retrieval, and analysis of data. Knowledge of research techniques and program management standards. General knowledge of Accounting. Ability to communicate effectively both orally and in writing to all levels of staff.

SALARY RANGE: \$42,547 - \$75,212 (Grade 76)

CONTRACT MANAGER
DESCRIPTION OF RESPONSIBILITIES AND DUTIES

Responsible for the management and process of contract development for provider network and claims management system for payment.

Develops authorization system to assure prompt quality adjudication of claims and quality service.

Oversees the coding process for claims payment.

Develops system to forecast management of IBNR and exposure.

Directs day-to-day operations for the entire contract process, from the initiation of a contract, responsibility for compliance crosscutting required for audit compliance, oversight of data entry.

Responsible for the approval process for contract invoices for payment and is responsible to ensure contract payments do not exceed the terms of the contract and the budget.

Meets with providers as technical advisor and is a representative of LME to problem-solve issues. Position researches, problem-solves and communicates responses to appropriate individuals or parties.

Develops system for appeal process for payment issues.

Position is responsible for ensuring the provision of adequate in-house training for Contract Management staff and other support staff in such areas as reimbursement fundamentals and procedures and computer applications. Position identifies or solicits specific areas where training is needed, organizes training schedules, coordinates the staff responsible for training, conducts training, and evaluates periodically for effectiveness.

MINIMUM QUALIFICATIONS:

Four-year college degree in Business, Management, Accounting or related field and minimum four years prior reimbursement/contract management experience to include supervision. Knowledge of accounting, reimbursement and/or managed care practices. Knowledge of established budgeting and accounting practices. Use of computer systems. Strong oral and written communication skills.

SALARY RANGE: \$32,290 - \$56,548 (Grade 70)

AREA PROGRAM CLOSE-OUT SPECIALIST
DESCRIPTION OF RESPONSIBILITIES AND DUTIES

Under the general direction/supervision of the CEO, COO and/or CFO, develop a systematic method for the purpose of closing out business activities associated with the Trend, Rutherford-Polk and Blue Ridge Area Programs and the transition to the LME.

Activities would include, but are not limited to:

Develop system to close out the financial records of the Area Program and to lead the close-out team through area program cost finding, financial audits of the area program and affiliate agencies. Assume responsibility for carrying out any financial settlements. Accounting activities would also include payroll pay-put of accrued vacation, regular accounts payable and accounts receivable. Supervise data entry of services to lead to provider payment and appropriate billing to Medicaid and other 3rd party sources. Settlement of IPRS earnings with the Division of MHDDSAS.

Develop method for access, storage, and securing of all Area Program financial, programmatic, clinical, and personnel files.

Provision of closing out contracts with Area program providers, agencies, affiliates.

Develop system for divestiture of remaining infrastructure to include furniture, computer systems, vehicles leased space, property and all functions associated with this.

Other projects related to various aspects of closing out the area program.

MINIMUM REQUIREMENTS:

This position requires a four year college degree in Business, Management, Accounting or related field and minimum four years prior experience and familiarity with the above.

SALARY RANGE: \$32,280 - \$56,548 (Grade 70)

PERSONNEL TECHNICIAN
DESCRIPTION OF RESPONSIBILITIES AND DUTIES

Manages all facets of a comprehensive human resource management program for the LME.

Develops, monitors personnel policies. Assures that all policies are current and follow state, federal, board guidelines. Makes recommendations for changing policies as law dictates. Reviews program operations and determines need for new or revised policies or procedures. Establishes and directs the implementation of policies.

Responsible for employee relations by providing guidance and technical assistance pertaining to disciplinary actions, grievances, appeals, unemployment hearings. Serves as technical assistant to employees, supervisors, and management in order to attempt to resolve problems before the formal grievance or disciplinary process is used.

Responsible for system of recruitment to include classification and salary.

Responds to issues from LME administration in reclassification, salary, position studies.

Monitors manpower planning and position management. Oversees preparation of status changes and responds to all requests from Management on same.

Completes and monitors pay plan in conjunction with the Office of State Personnel.

Assures that management maintains appropriate hiring practices. Ensures supervisors are selecting or rejecting applicants in conformance with legal requirements and policy.

Monitors system for the updating of job descriptions.

Responsible for benefit administration including leave benefits, worker's compensation.

Directs the development, maintenance, and monitoring of a performance evaluation system based on established criteria for both permanent and probationary employees. Oversees coordination of merit/COL/bonus increases.

Administers the Equal Employment Opportunity (EEO) program for the LME. Serves as the designated EEO officer for the LME

Directs the physical maintenance of all personnel records, position control medical, training, privileging files. actions.

Maintenance of leave reporting system.

Provides orientation for new employees.

Continuously updates employee handbook and other communication tools designed to inform employees of the LME's operations and policies.

SALARY RANGE: \$29,975 - \$46,778 (Grade 66)

ADMINISTRATIVE ASSISTANT
DESCRIPTION OF RESPONSIBILITIES AND DUTIES

This position is responsible for the provision of administrative support and assistance to the Chief Executive Officer and other senior executive staff, as needed, in carrying out the LME administrative functions.

Provide research for topics as requested by CEO for position papers, proposals, grants, and special reports/projects. Responsible for the development and coordination of the above projects at the request of the CEO. May interpret and maintain reports as needed.

Initiates responses and correspondence for CEO, develops and composes letters, memoranda, e-mails.

Gathers, analyzes and interprets statistical data.

Assists CEO in administrative details related to program planning efforts.

Position will be involved in some budget reporting and monitoring at the request of the CEO

Creates computer generated reports specific to areas such as utilization, maintenance and monitoring of services.

Provides administrative consultation, guidance and technical assistance to agency staff and the public, as needed.

Works with agency staff regarding system issues.

Assists CEO in organizing meetings and schedule, coordinating with Secretary.

Responsible for a wide range of public contact, both face-to face and telephone.

Position may organize, monitor and assess for completeness, the policies and procedures manual and other manuals for approval by Board and distribution to pertinent staff.

Supervises administrative secretary.

MINIMUM QUALIFICATIONS:

Completion of high school and a minimum of four years of progressively responsible administrative/office management experience.

SALARY RANGE: \$23,716 - \$40,544 (Grade 63)