

Code: 1542

Title: HEALTH REGULATORY AND COMPLIANCE COORDINATOR-PHS

SUMMARY: Plans, coordinates, monitors, and participates in Pima Health Systems (PHS) administrative and operational activities related to member and provider grievance and appeal processes associated with the Pima County's managed care organization and Corporate Compliance Program.

DUTIES/RESPONSIBILITIES: (Work assignments may vary depending on the department's needs and will be communicated to the applicant or incumbent by the supervisor.)

Plans, organizes, coordinates, and administers PHS' member and provider grievance and appeals processes for claims alleging misrepresentation, bad faith, breach of contract and/or non-compliance with policy according to applicable law or regulation;

Provides administrative review and resolution of member and provider appeals in compliance with State Law, statutory or regulatory provisions, contractual obligations, State Medicaid Rules and Regulations and Plan policies and procedures within mandated time frames;

Prepares case documentation, coordinates attendance of affected parties, and acts as Plan representative for grievance hearings at the State level, and for subsequent proceedings as required;

Identifies grievances relative to the Plan's Quality Management (QM) process and forwards to the QM Division for action, pursuant to applicable State and Federal laws;

Designs, conducts, and completes comparative studies on grievance trends and member/provider satisfaction data to identify areas for improvement and prepares written reports and recommends corrective action to management;

Prepares and submits status reports to the regulatory agencies for all grievances submitted and type/outcome of grievances in compliance with applicable directives;

Coordinates with appropriate medical and administrative personnel and agencies to resolve problems;

Acts as the Plan's point-of-contact for providers, members, and all levels of PHS' staff providing functional and technical expertise for mandated Appeals and Grievance processes and HIPAA Privacy Rules;

Reviews and makes determinations on all requests made for plan members' records for validity and authority to obtain records;

Researches and keeps current on laws, rules and regulations and relevant legislation governing Plan operations, and ensures that Plan policies, procedures and activities comply with applicable mandated grievance and appeals process and third party reimbursement and keeps Administrator apprised of any changes;

Develops training material relating to Corporate Compliance, Fraud and Abuse, Privacy, Confidentiality and HIPPA guidelines and any other related topic needed to meet required training needs, and conducts training of staff members through lectures, demonstrations, exercises and workshops to assure compliance with State and Federal regulatory requirements;

Assists the Compliance Officer in investigations and ongoing activities of the department's compliance program;

Supervises, trains, and evaluates clerical support and para-professional staff, and makes effective recommendations on hiring, termination, and related personnel activities;

Represents the Plan at various meetings, conferences, and/or on committees and either gathers or provides information relative to specialized programs;

Analyzes data and prepares program activity reports and statistical materials for management review;

Maintains manual and automated databases and files of grievances and appeals.

KNOWLEDGE & SKILLS:

Knowledge of:

- principles and practices of business and program administration;
- principles and practices of managed care delivery system, benefit packages, compliance, billing, and claims;
- principles and practices of effective staff supervision, training and evaluation;
- Federal Privacy Laws, AHCCCS/ALTCS rules and regulations and applicable Arizona Revised Statutes;
- data and statistical analysis techniques and application to planning studies and projects;
- principles and techniques of conflict mediation and resolution;
- employee training and development methods, techniques and practices;
- applications of automated information systems;
- medical terminology, conditions, and disease processes;
- principles and techniques of effective communication, both written and oral;
- interviewing techniques and procedures.

Skill in:

- planning and coordinating administrative services and unit activities;
- reviewing, evaluating, and interpreting contractual agreements and monitoring compliance;
- establishing and maintaining effective working relationships with governmental agencies, community, and special interest groups;
- reviewing and analyzing insurance and Federal Privacy Laws, AHCCCS/ALTCS rules and regulations and applicable Arizona Revised Statutes and legislation proposals;
- identifying needs and developing and implementing processes to meet those needs;
- assessing training needs, using industrial standards and regulatory guidance;
- interpreting and applying applicable legal, procedural and program-specific guidance, direction and mandated requirements;
- analytical problem-solving and study and research methodology;
- communicating effectively, both orally and in writing;
- conducting and documenting interviews;
- use of automated information systems to maintain or produce data and administrative reports and correspondence.
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MINIMUM QUALIFICATIONS:

EITHER:

(1) A Bachelor's degree from an accredited college or university with a major in public administration, health care or business administration, management, accounting or closely related field and two years of experience coordinating and monitoring client/member or provider grievance and appeal processes in a managed care organization, plus one year of supervisory or management experience (which may be concurrent with other required experience).

OR:

(2) An Associate's degree from an accredited college, university, technical, trade, or vocational school in public, health care or business administration, management, legal assistant/paralegal or closely related field and four years of experience coordinating and monitoring client/member or provider grievance and appeal processes in a managed care organization, plus two years of supervisory or management experience (which may be concurrent with other required experience).

OR:

(3) Six years of experience coordinating and monitoring client/member or provider grievance and appeal processes in a managed care setting, plus two years of supervisory or management experience (which may be concurrent with other required experience).

OTHER REQUIREMENTS:

Licenses and Certificates: Some positions may require a valid Arizona Class D Driver's License at the time of appointment or prior to completion of probation.

Physical/Sensory Requirements: Physical and sensory abilities will be determined by position.

This class specification is intended to indicate the basic nature of positions allocated to the class and examples of typical duties that may be assigned. It does not imply that all positions within the class perform all of the duties listed, nor does it necessarily list all possible duties that may be assigned.

