Management Analyst / CS-343-14/ $103,605 - $133,476:

The Management Analyst is responsible for assisting, providing guidance and counseling to District residents that are covered by the Health Care Bill of Rights. Organizes, prepares, and presents complex, analytical written documents, oral reports and briefings on various healthcare administration topics. Engages in problem-solving tasks on policy issues involved in highly technical services and recommends solutions to the Director on policy matters and critical issues. Develops and manages the tracking system for consumer and provider complaints. Additionally, he/she is responsible for case management for Medicaid, Medicare, Commercial, and Tri-Care cases.

Qualifications:

- Demonstrated extensive knowledge of Medicaid and S-CHIP/CHIPRA requirements from the Centers for Medicare and Medicaid Services (CMS), District laws and rules, Mayor's Orders and court decisions.
- Knowledge of the theories, concepts, principles, practices, methods, and techniques of public health program administration and aspects of public health to resolve questions, problems, and issues and to take actions which significantly affect general public health policies.
- Mastery of analytical and evaluative methods and techniques for assessing program development and improving organizational effectiveness and efficiency.
- Extensive knowledge of policy development, claims administration and project management.
- Knowledge of Health Care Bill of Rights laws and Health Care Ombudsman Program Establishment Act of 2004 rules and regulations.

Education:

- A bachelor's degree in business administration or related field or an equivalent combination of relevant education, experience, and training is preferred.

Management Analyst / CS-343-13 / $87,657 - $112,956:

The Management Analyst serves as a lead on projects and programs including management of budget, providing guidance to team members, and developing and implementing work plans. Coordinates and communicates with District officials, health care providers, and stakeholders serving individuals receiving Medicaid Long Term Care Supports and Services. Develops procedures and guidelines for monitoring and evaluating eligibility determinations, cost containment and quality control processes in the area of Medicaid financed programs. Develops and maintains a comprehensive process that includes development of tools for program evaluation, data tracking, analysis and reporting of Medicaid financed programs to Federal and District authorities.

Qualifications:

- Demonstrated analytical ability and critically review, assess and analyze policies and programs of Medicaid financed programs for individuals receiving Medicaid Long Term Care Supports and Services.
- Ability to research, analyze, interpret financial, statistical and accounting data and information to prepare narrative reports.
- Experience with the Medicaid program, particularly Medicaid-finance programs targeted to individuals receiving Medicaid Long Term Care Supports and Services.
- Expert knowledge of and skill in the application of the theories, concepts, principles, practices, methods, and techniques associated with healthcare delivering services to individuals receiving Medicaid Long Term Care Supports and Services.
- Skill in applying judgment to discern program and performance deficiencies and conditions and to interpret guidelines.

Education:

- A bachelor's degree in business administration or related field or an equivalent combination of relevant education, experience, and training is preferred.