TOP STORIES

Covered California Premiums to Increase 4% in 2016
UnitedHealth to sell plans on exchange in five regions

Covered California officials say premiums for health plans will increase an average of 4% in 2016 and that two new insurers will be joining the exchange.

Covered California says premium increases will vary by region with costs rising more in Northern California than in Southern California. Overall, the premium increases are slightly below the 4.2% increase in 2015.

"The health plans know that if they price their products too high and consumers know it's too high, because it's an apples-to-apples comparison, they will not get enrollment," said Covered California executive director Peter Lee in explaining the modest rate increase.

Rates for health plan members in Northern California will increase 7% in 2016 to an average premium of $384. In Southern California, rates will increase 1.8% to an average premium of $296. Premium increases will also vary by county. In Monterey, San Benito, and Santa Cruz counties, rates will jump 12.8%, but will increase only 3.4% in San Francisco County. In Southern California, rates in San Diego County will increase 2.8%, but will decrease 0.5% in Imperial County.

"Healthcare is local," said Lee. "And as good as these average premium changes are across the state, it is important to look locally at each region. For example, in the regions that encompass Los Angeles, the most populous regions in the state, the weighted average increase for consumers who stay in their current plan is only 1.8%.

Reaction to the announced rates for 2016 was largely positive. The California Association of Health Plans (CAHP), which advocates for insurers in the state, says the rate increase is modest and reflects the ongoing increase in the cost for medical care.

"The mix of a competitive health insurance market, high enrollment, and a commitment to affordability has resulted in three consecutive years of modest premium pricing," says CAHP president and CEO Charles Bacchi. "However, premiums reflect the underlying cost of care and as costs for doctors, hospitals, and prescription drugs rise, [they] impact the price we all pay for health coverage."
IN BRIEF

Avanti Hospitals has named Michael Rembis as its corporate chief executive officer. Avanti operates four hospitals in Southern California that include Memorial Hospital of Gardena, Community Hospital of Huntington Park, Coast Plaza Hospital, and East LA Doctors Hospital. Rembis has 25 years of executive experience in hospital leadership that includes top administrative positions at Providence Saint Joseph Medical Center, Riverside Community Hospital, and JFK Medical Center. “Michael’s expertise and proven leadership, developed across a diverse spectrum of delivery settings in for-profit and non-profit institutions, has brought the hospitals and organizations he has led exceptional results,” says Joel Freedman, president of Avanti Hospitals.

A facility formerly known as Palm Drive Hospital is due to re-open in early August as Sonoma West Medical Center. According to a report in the Santa Rosa Press Democrat, the new 25-bed hospital in Sebastopol will include an emergency department, 20 medical-surgical beds, and 5 intensive care beds. The hospital is undergoing final inspections by the California Department of Public Health and other agencies that will provide certifications for it to open. “I’m not anticipating there will be any deficiencies that will prevent us from re-opening the hospital,” says Raymond Hino, CEO of Sonoma West Medical Center. Palm Drive Hospital shut down in 2014 after

TOP STORIES CONTINUED FROM PAGE 1

Covered California cont.

Consumer advocacy group Consumer Watchdog says the rate increases were on par with those predicted in a Kaiser Family Foundation study of premium increases in major metropolitan areas and cautioned consumers to “read the fine print” before buying policies.

“On top of an increased sticker price, consumers should watch out for the ‘hidden premiums’ owed if they use their coverage and face thousands of dollars in high deductibles or unlimited out-of-pocket costs when shrinking narrow networks force them to see out-of-network providers,” says Carmen Balber, executive director of Consumer Watchdog.

Covered California also announced that UnitedHealth and start-up insurer Oscar Health Plans will begin selling plans on the exchange in 2016. UnitedHealth will be selling plans in five of Covered California 19 regions of the state where fewer health plan options are available to consumers. Those regions include the rural Northern Counties region, the Monterey Coast, the Central Coast, Central San Joaquin, and Eastern Counties.

Oscar Health, which currently operates in New Jersey and New York, will offer plans in the Los Angeles County Southwest and Orange County regions. “We have more quality plans to choose from, which are serving more parts of the state,” says Anne Price, director of plan management for Covered California. “We’re giving consumers the choice of more doctors and more hospitals to ensure they can get the right care at the right time.”

In a statement, Consumer Watchdog questioned why UnitedHealth will be limited to selling plans in only five regions of the state next year. “It’s a genuine mystery why Covered California would protect the state’s three health insurance giants from competition from their biggest rival,” says Balber. —DOUG DESJARDINS

Anthem Blue Cross Merger with Cigna Raises Concerns
State insurance chief cites consolidation concerns

The proposed merger between Anthem Blue Cross and Cigna is expected to draw heavy scrutiny from federal agencies but isn’t likely to significantly change the health insurance landscape in California.

The latest entry in a wave of mega-mergers between insurers came July 26, when Anthem announced it would acquire Cigna in a deal worth an estimated $54.2 billion with debt factored in. The deal would make Anthem the largest insurer in the country based on total enrollment. The combined company would...
years of financial problems linked to increased competition from other hospitals in the region. Remodeling and construction of the new facility was headed by the Sonoma West Medical Foundation.

› Nurses at Kaiser Permanente Los Angeles Medical Center have voted to join the California Nurses Association (CNA). Nurses voted 696–305 to join CNA instead of the United Nurses Associations of California and CNA, pending certification of the election results, will represent approximately 1,200 nurses working at Kaiser Permanente's flagship hospital in Los Angeles. In a statement, Kaiser's vice president of government relations John Nelson says that "we will respect the majority decision" and that "we look forward to working with CNA to reach a fair and equitable contract to provide our nurses at Los Angeles Medical Center with an excellent place to work." The election results must still be certified by the National Labor Relations Board.

› Rideout Memorial Hospital has completed a CMS validation test that will allow it to meet the Medicare Conditions of Participation for hospitals. "Step by step, each member of the Rideout family has done—and continues to do—the hard work needed to improve our quality, restore our compliance, and build a sustainable future," says Robert Chason, interim CEO of Rideout. According to a report in the Sacramento Business Journal, Rideout has been under scrutiny for nearly two

TOP STORIES CONTINUED FROM PAGE 2

Antem Blue Cross cont.

have about 53 million covered lives in the United States if the deal closes as scheduled in the second half of 2016. Regulatory approval is pending.

California insurance commissioner Dave Jones says the state Department of Insurance will review the proposed merger and expressed concerns about further consolidation among insurers in the state.

"California's health insurance market already suffers from consolidation, with the four largest health insurers in the individual market controlling more than 85% of the market," he says. "Further consolidation will result in even less competition among health insurers and will leave consumers and employers with fewer choices and the potential for greater premium increases."

According to a 2014 report from the California HealthCare Foundation, the top insurer in the state is Kaiser Permanente with a 42% share of the private market followed by Anthem with 20% and Blue Shield with 15%. Cigna ranked seventh with a 4% market share behind Health Net, UnitedHealthcare, and Aetna. Though the merger between Anthem and Cigna would make Anthem a larger player in the California market, it would not increase its market share dramatically.

"Cigna does not have a big market share in California, so this proposed merger is not going to change the landscape that much in the state," says Gerald Kominski, director of the UCLA Center for Health Policy Research. "It effectively means the combination of a small player (Cigna with about a 4% market share in California in the private market) with a big player (Anthem with about a 20% market share in the private market)."

While the impact in California would not be dramatic, the deal is likely to raise concerns in other states where Cigna and Anthem both have a large share of the market. "The implications nationally may result in less competition in markets and is thus likely to generate more regulatory scrutiny, especially given the size of the combined company," Kominski says.

Tam Ma, policy counsel for healthcare advocacy group Health Access California, says the deal could be bad for consumers. "Anthem should not be allowed to get bigger without getting better," says Ma. "Anthem has pursued rate increases that California regulators found to be unreasonable and its provider directories are inaccurate and unreliable, making it difficult for consumers to find in-network doctors who are accepting new patients."

Ma said that "these insurance deals need to be heavily scrutinized by state regulators to ensure they're in the best interests of patients and the public" and that regulators "need to ensure that these deals actually benefit the health system on which we all rely." —DOUG DESJARDINS
years after a regulatory survey uncovered patient safety issues ranging from improper use of restraints to inadequate infection safety control. The hospital hired Chason, a member of the Rideout Memorial Hospital board of directors and a former CEO of UC Davis Medical Center, as interim CEO in 2014 for the 149-bed hospital located in Marysville.

Prospect Medical Holdings has announced the opening of Los Angeles Community Hospital in Bellflower. The hospital formally known as Bellflower Medical Center re-opened on July 23 after receiving required approvals from state health officials and the city of Bellflower. According to a press release from Prospect Medical, the hospital is currently operating "a 32-bed voluntary adult inpatient behavioral unit" that will provide services for people with problems such as depression. It added that "other proposed services, including urgent care and medical and surgical inpatient services" will follow after Prospect conducts a "community needs assessment to help determine what additional services to provide." Bellflower Medical Center, a 142-bed acute care hospital, was shut down in April 2013 along with four other hospitals by parent company Pacific Health Corp. due to financial problems. It was purchased by Prospect Medical Holdings in 2014.

The California Department of Public Health (CDPH) and St. Joseph Health System are partnering on a pilot project in which St. Joseph will send

TOP STORIES

Aid-in-Dying Lawsuit Dismissed by San Diego Judge
Attorney says plaintiffs plan to appeal decision

A San Diego judge has dismissed a lawsuit that sought to overturn a law prohibiting physicians from providing aid-in-dying to terminally ill patients.

San Diego Superior Court Judge Gregory Pollack says the state legislature or voters should decide whether the state should pass a law that allows physicians to assist terminally ill people to end their lives. "You're asking this court to make a new law," Pollack said at a July 27 hearing. "If a new law is made, it should be by the legislature or by a ballot measure."

The lawsuit was filed in May on behalf of three state residents with terminal cancer; Christy O’Donnell of Valencia, Elizabeth Wallner of Sacramento, and Wolf Breiman of Ventura. The lawsuit challenged California Penal Code section 401, which makes it a crime to "deliberately advise or encourage another to commit suicide" or end their life. The lawsuit also included as a plaintiff Compassion & Choices, a national patient rights advocacy group.

John Kappos, the lead attorney for the plaintiffs, says he is disappointed with the decision and that an appeal is planned. "We are hopeful that an appeals court will recognize the rights of terminally ill adults like Christy O’Donnell—who are facing horrific suffering at the end of their lives that no medication can alleviate—to have the option of medical aid-in-dying."

Earlier last month, a bill that would have allowed patients to request aid-in-dying from their physicians was shelved in the state Assembly after clearing the state Senate in June. Senate Bill 128 was withdrawn from consideration in the Assembly Health Committee on July 7 by the bill's authors due to a lack of votes.

SB 128 was authored by senators Lois Wolk (D-Davis) and Bill Monning (D-Carmel) and would have allowed physicians to prescribe medication to terminally ill patients who want to end their lives. The bill would have required two physicians to make separate diagnoses that a patient is terminally ill and has less than six months to live.

Opponents of SB 128 included two state oncology associations, religious groups, and the Disability Rights Education & Defense Fund, which stated that "adding this so-called 'choice' into our dysfunctional healthcare system will only push people into cheaper, lethal options." A group called Californians against Assisted Suicide made a similar argument and said assisted suicide would "quickly become another form of treatment, and the cheapest."

Wolk and Monning said they plan to re-introduce Senate Bill 128 for the 2016 legislative session.—DOUG DESJARDINS

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its structured pathology cancer data directly to the California Cancer Registry (CCR). Ten St. Joseph hospitals will send cancer data directly to the CCR in a collaboration between the CDPH, mTuitive, and the College of American Pathologists. “Every second we save in sharing data gives researchers more time to spend on curing cancer,” says CDPH director Karen Smith, MD. “This partnership is another way in which the CDPH works with the private sector and healthcare systems to optimize the health and well-being of people in California.” The CDPH says other hospitals in the state are expected to join St. Joseph in sending cancer data to the CCR in the future.

» Napa County has named Karen Relucio, MD, as its chief public health officer in an appointment that was effective July 6. Relucio, who is the former assistant health officer for San Mateo County, replaces Karen Smith, MD, who left Napa County to head the California Department of Public Health. “Dr. Relucio brings with her a wealth of public health knowledge and expertise that will greatly benefit our community,” says Howard Himes, director of the Napa County Health and Human Services Agency. Relucio, who is board-certified in infectious diseases and internal medicine, completed her fellowship training at Stanford University Medical Center in 2003.

» Crestwood Behavioral Health Inc. has been issued a Class AA citation from the California Department of Public Health (CDPH) for an incident involving the death of a resident at its skilled nursing facility in Freemont. The AA citation, which carries a $100,000 fine, was issued following an investigation that found “deficiencies that were determined to have been a direct proximate cause of death of a patient or resident.” The case involved the death of a patient in July 2014 “who choked on food and died.” An investigation into the resident’s death found that the facility “failed to follow their policy and procedure to provide a safe dining experience” for residents. Crestwood Behavioral Health officials could not be reached for comment regarding the citation.

» Heritage Provider Network president and CEO Richard Merkin, MD, have committed funding to establish the Merkin Fund for Professorships in Regenerative Medicine at the Keck School of Medicine at USC. The funding from the Merkin Family Foundation will provide support and training for three professorships in regenerative medicine at USC. “This gift supports USC’s progress in assembling and cultivating one of the most dynamic teams of research scientists in the field of regenerative medicine,” says Andy McMahon, chief of the Department of Stem Cell Biology and Regenerative Medicine at the Keck School of Medicine. “I am confident that these faculty will make transformational contributions to human health in the years to come.”

**EVENTS**


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**FEATURED CAREER OPPORTUNITIES**

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**Executive Director Claims Administration #322301**
Bachelor's degree or equivalent/relevant experience required, Master’s degree preferred. Minimum 12 years of successful history in operations in a managed care environment, a minimum of 7 years directly with IPA or medical group in a claims payment environment.

**Director, Populations Health Analytics #323043**
Master's degree in Computational Science or Economics, 5 years' experience in healthcare finance, Population Health, ACO, Health Plan, medical management/cost of care or decision support environment; Proven quantitative and analytical skills. Experienced in the development of financial analysis, reporting, predictive analytics and claims systems.

**Director, Provider Networks/Relations #323082**
Bachelor's degree required and 7-10 years' experience in Provider Relations, Customer Service, Credentialing or equivalent experience. A minimum of 5 years management experience required.

**Director, Inventory & Distribution #323398**
Master's degree required; Bachelor's will be considered with significant qualifications and experience relating to healthcare industry supply chain management; 10 years' progressively responsible managerial experience in healthcare and/or Lean supply chain management.

**OPERATIONS**
- Manager, Accounting
- Manager, System Contracting
- Supervisor Claims, Production
- Manager, Coding Compliance
- Decision Support/Financial Analyst I
- Manager, Materials Services
- Practice Manager
- Manager, Lean Fellow
- Clinical Pharmacist
- Internal Auditor Manager
- Internal Auditor Manager
- Supervisor, Credentialing
- Business Systems Specialist (Tapestry)
- And many more--------

**CLINICAL**
- RN Supervisor, Asst. Supervisor, Teamleads
- Practice Manager
- Clinical Application Specialist (Radiant)
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- Clinical Application Specialist (Orders)

**INFORMATION SERVICES**
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- And many more--------

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CLAIMS QUALITY AUDITING & TRAINING MANAGER
Bachelor's degree preferred. Education requirement may be waived if candidate has extensive supervisory and operational experience in a medical claims payer environment. Five (5) years of medical claim operations experience with at least three (3) years in a related supervisory capacity. Compliance audit experience preferred. Extensive experience writing policies & procedures and training documentation. Highly organized with the ability to balance multiple projects and meet deadlines. Strong presentation skills. Ability to transform concepts into business operations. Experience in a Lean strategy environment highly desired.

Solid understanding of Medi-Cal and Medicare rules and regulations governing claims adjudication practices and procedures preferred. Demonstrated business training principles and techniques. Analytical skills with emphasis on time management, quality statistics, and problem solving. Strong writing, organizational, project management, presentation and communication skills required. Must have a high degree of patience, excellent interpersonal/communication skills.

CLAIMS QUALITY AUDITING SPECIALIST
Possession of a High School diploma or equivalent. Two (2) years experience in examining and processing medical claims; Medicare/Medi-Cal experience.

Responsible for ensuring the integrity of all data created and updated by the Claims Processing staff. The QA Specialist will utilize Cost Management tools, identify training needs, and define effective and efficient methods for accurate data entry and adjudication. Review and assess data reports and audit Claims Processor output to confirm payment accuracy and completeness of data entry. Experience with Microsoft applications preferred. ICD-9 and CPT coding and general practices of claims processing. Professional demeanor, excellent communication and interpersonal skills, strong organizational skills. Prefer knowledge of capitated managed care environment.

DIRECTOR OF CALL CENTER SYSTEMS, QUALITY & TRAINING
Bachelor’s degree in Business Administration or related field, or five (5) years of equivalent work experience in lieu of degree. Previous experience with workforce and forecasting analysis utilizing industry software. Experience in a multi-skill, multi-site call/contact center operation is required. Experience with databases and/or data manipulation. Knowledgeable in call center operations including quality review and training experience. Highly organized with the ability to balance multiple projects and meet deadlines. Extensive experience writing policies and procedures and training documentation. Prior project management experience with the ability to work independently with the ability to develop concepts into business operations.

The Reporting Analyst will be responsible for providing support to the Claims Processing staff. The QA Specialist will utilize Cost Management tools, identify training needs, and define effective and efficient methods for accurate data entry and adjudication. Review and assess data reports and audit Claims Processor output to confirm payment accuracy and completeness of data entry. Experience with Microsoft applications preferred. ICD-9 and CPT coding and general practices of claims processing. Professional demeanor, excellent communication and interpersonal skills, strong organizational skills. Prefer knowledge of capitated managed care environment.

Five (5) or more years of healthcare call center experience working in a health care delivery setting. Experience in an HMO, managed care, knowledge in Medi-Cal, Healthy Families, Healthy Kids, and Medicare Programs preferred. Proficient in microcomputer applications. Excellent written and verbal communication, interpersonal skills, ability to establish and maintain effective working relationships with others, ability to supervise and train team member’s strong organizational skills, detail oriented, and sound decision making skills required. Ability to critically review data and implement operational recommendations. This role requires high degree of patience and strong ability to lead team members through inherent interpersonal challenges.

MEDICARE CLAIMS SUPERVISOR
Possession of a bachelor’s degree or equivalent work experience in a Managed Care or Health Care environment. Four (4) to six (6) years experience in a managed care environment in the areas of claims processing, and or provider payment appeals and disputes, with at least one (1) year in a supervisory capacity. A thorough understanding of claims industry and customer service standards. Prior Medicare experience preferred.

Extensive knowledge of ICD9, CPT and Revenue Codes. Solid understanding of the CMS and DHCS claim regulations, including AB1455. Principles and techniques of supervision and training. Analytical skills with emphasis on time management, database maintenance, spreadsheet manipulation, and problem solving. Strong writing, organizational, project management, and communication skills proficiency required. Must have a high degree of patience, excellent interpersonal and communication skills.

QUALITY ASSURANCE NURSE RN/LVN – COMPLIANCE
Possession of a bachelor’s degree at an accredited four (4) year institution preferred. Possession of a RN/LVN California License. Three (3) or more years of demonstrated experience in an office environment, at a professional level, preferably in a Compliance function. Two (2) years experience in a managed care environment.

Demonstrated proficiency in Microsoft Office products (Word, Excel, PowerPoint, Outlook, etc.). Excellent interpersonal and communication skills, strong organization skills, ability to establish and maintain effective working relationships both within and outside of the organization. A wide degree of creativity and latitude is expected.

REPORTING ANALYST – COMPLIANCE
Possession of a high school diploma or equivalent. Bachelor’s degree preferred. Five (5) years experience required in an office environment.

The Reporting Analyst will be responsible for providing support to the Compliance Department by developing, tracking, manipulating and monitoring reporting activities including working with the appropriate departments for regulatory reporting. Strong organizational skills and attention to detail. Proficient knowledge of Microsoft Access, Word and Excel required. Project Management experience preferred.

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As a Senior Director, you will oversee financial performance and clinical metrics of institutional business, including all hospital risk pools and hospitalist team managing patients in acute and skilled nursing levels of care. The Senior Director will investigate requests and problems, make presentations to senior leadership, ensure data documentation is accurate and ensure performance achieved is at or above target levels. Pertinent data and facts will be reviewed to identify and solve issues and mitigate risks, prioritize your work load, and work on ad hoc projects as required.

This position requires dedication to performance improvements across the institutional line of business in an objective way. The Senior Director will resolve complex issues and identify new opportunities by applying strategic insight, intellectual honesty, and analytical structure coupled with process improvement experience to achieve results.

Responsibilities and Functions:

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- Support short and long term operational/strategic business activities
- Develop recommended business solutions through research and analysis of data and implement when appropriate
- Lead initiatives to increase efficiency and maximize the revenue opportunities while leading innovation and collaboration with internal/external partners
- Review, create, and/or maintain workflows to ensure they are up-to-date and operationally efficient
- Provide guidance, expertise, and/or assistance to internal and/or external partners (e.g., claims; call center; benefits; clinical) to ensure programs and strategies are implemented and maintained effectively
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Director of Process Improvement
Develop and implement business process excellence initiatives throughout the organization to analyze and address process and operational inefficiencies by utilizing Six Sigma/LEAN methodologies. Responsibilities: Develop, direct, implement, and execute business process excellence and process improvement initiatives utilizing Six Sigma/LEAN methodologies, including process mapping and process design. Develop and implement key metrics across the organization to review past, current, and future performance of business processes. Evaluate interventions for effectiveness and return on investment. Oversee data analysis and gather processes/programs to establish costs and benefits of process effectiveness and efficiency. Conduct analysis of business processes across the organization, identify gaps in the business process, determine its impact to the organization, and recommend action plans and timeline to address these issues. Collaborate with various functional areas to achieve optimal results in process redesign and implementation of new methodologies. Identify barriers to implementation and develop and propose solutions that address both business needs and customer satisfaction.

Education/Experience: Bachelor’s degree in business, healthcare administration, related field, or equivalent experience. 7+ years of process optimization, process improvement, or project management experience. Experience with Six Sigma/LEAN methodologies. Knowledge of process mapping, process design, and workflow management software and applications.

License/Certification: Six Sigma/LEAN Certification preferred.

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Compliance Specialist
Ensure compliance with contractual requirements and federal and state government reporting and regulations. Maintain government relations for compliance activities.

Responsibilities: Ensure compliance with contract provisions with various agencies and applicable State and Federal laws. Serve as compliance resource for day-to-day processes. Analyze and determine the best course of action for each inquiry/problem. Act as primary contact for initiating and coordinating compliance projects. Develop and update plan policies and procedures to ensure compliance with federal and state requirements. Conduct periodic assessments and audits to ensure compliance with contractual and regulatory requirements and timeliness of submission. Oversee the day-to-day health plan policies and procedures to ensure federal and state regulatory compliance.

Education/Experience: Bachelor’s degree in related field or equivalent experience. 5+ years of compliance or regulatory experience. Advanced experience with Microsoft Office applications. Knowledge of business operations related to managed care preferred.

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Data Analyst III
Responsible for analytic data needs of the business unit. Handle complex data projects and acts as lead for other Data Analysts.

Responsibilities: Provide advanced analytical support for business operations in claims, provider data, member data, clinical data, HEDIS, pharmacy, external reporting. Extract, load, model, and reconcile large amounts of data across multiple system platforms and sources. Review data to determine operational impacts and needed actions; elevate issues, trends, areas for improvement and opportunities to management. Develop reports and deliverables for management. Model data using MS Excel, Access, SQL, and/or other data ware house analytical tools. Ensure compliance with federal and state deliverable reporting requirements by performing data quality audits and analysis. Assist with training and mentoring other Data Analysts.

Education/Experience: Bachelor’s degree in related field or equivalent experience. 4+ years of statistical analysis or data analysis. Advanced knowledge of Enterprise Reporting and Analysis tools, SQL, and Microsoft Office applications, including Excel and Access. Experience managing projects or heavy involvement in project implementation. Healthcare experience preferred.

Please submit your resume to BGLICK@CENTENE.COM

Manager, Medical Review Unit
Manage the review of medical claims for billing coding, other compliance or reimbursement issues; assist with non-clinical aspects of medical review, project management functions.

Responsibilities: Manage work flow of medical review unit, assist with policy and procedure development and train staff. Develop, implement and maintain production and quality standards for medical review unit staff. Oversight of standalone office location (daily personnel issues, supplies, staffing, and safety). Investigate medical claims, records for billing, coding, and compliance or reimbursement issues and make payment.


Licensure/Certification: RN license.

Please submit your resume to BGLICK@CENTENE.COM

Medical Review Nurse
Perform retrospective review of large hospital and physician claims for admission appropriateness, coding, length of stay, and pricing. Review retrospective medical necessity appeals against medical review criteria to make benefit determinations.

Responsibilities: Perform retrospective high dollar claims for benefit, pricing-determination. Collect hospital medical records as appropriate and work with related hospital staff. Work with Finance Department to determine appropriateness of pricing. Maintain appropriate records, files, documentation, etc.

Education/Experience: Bachelor’s degree in Nursing or related field. Licensed or Registered Nurse. Advanced degree and/or certification preferred. 2+ years in acute care nursing and utilization review. Knowledge of managed care programs and practices required.

License/Certification: Licensed or Registered Nurse.

Please submit your resume to BGLICK@CENTENE.COM
### Featured Career Opportunities

**Gold Coast Health Plan** is currently accepting applications for the following positions:

- **Health Education Program Supervisor**
- **Senior Decision Support Analyst**
- **Health Navigator**
- **Utilization Review RN**
- **Receptionist**
- **Claims Analyst II**

All qualified candidates must submit an online application. Online applications and full job descriptions can be found at: [http://www.goldcoasthealthplan.org/about-us/careers.aspx](http://www.goldcoasthealthplan.org/about-us/careers.aspx)

**CLINICAL PHARMACIST (FORMULARY)**  
Req. #15-1817

**COMMUNITY OUTREACH REP (NORCAL)**  
Req. #15-1807

**COMPLEX CARE MANAGER RN**  
Req. #15-1859

**COMPLEX CARE MANAGER RN - NFLOC**  
Req. #15-1862

**DATA ANALYST SR. – HEALTHCARE SERVICES**  
Req. #15-1840

**DATA ANALYST SR. – HEDIS & MEDICARE STAR**  
Req. #15-1694

**DATA ANALYST SR. (PROVIDER SVCS)**  
Req. #15-1837

**DIRECTOR RISK ADJUSTMENT PROGS & AUDIT**  
Req. #15-1827

**HEALTHCARE INFORMATICS ANALYST II**  
Req. #14-1588

**HEALTH PROMOTION RN**  
Req. #15-1805

**MANAGER QUALITY ASSURANCE & TESTING**  
Req. #15-1779

**PHARMACY ANALYST**  
Req. #15-1739

**PROJECT MANAGER**  
Req. #15-1812

**RECOVERY SPECIALIST**  
Req. #15-1735

**SALES OPERATION SPECIALIST**  
Req. #15-1821

**TEMPORARY SALES REP**  
Req. #15-1845

For more information, please visit our website at: [http://www.scanhealthplan.com/careers/](http://www.scanhealthplan.com/careers/)

### GROWTH AND DEVELOPMENT FIELD REP

The **Growth and Development Field Rep** is responsible for planning and executing marketing projects to generate new member prospects and improve member retention. This position is also responsible for cultivating and managing all community relationships as well as identifying, organizing and executing events where a company representative is needed.

**RESPONSIBILITIES AND FUNCTIONS**

- Devise marketing projects with the goal of increasing company awareness and increasing sales and profits.
- Plan, organize, and execute marketing projects.
- Create programs that drive brand loyalty.
- Attend health care and health plan events to represent company.
- Coordinate and attend company sponsored events.
- Keep abreast of industry trends, competition, and new opportunities.
- Support all company initiatives, give actionable feedback, share best practices and serve as advocate and information source for company.
- Other duties as assigned

**Level of Experience**

- A minimum of 1 year experience in health care preferred
- 2-3 years’ minimum experience with event and project coordination
- Specific Knowledge, Skills, and Abilities
- Highly confident in speaking to large and small groups
- Computer literate in Microsoft Word, Excel, PowerPoint Strong verbal and written communication skills

For immediate consideration, please email/fax resume with salary requirements: [HR@AppleCareMedical.com](mailto:HR@AppleCareMedical.com) or Fax 714.443.4540
MEDICARE PART D ANALYST
Bachelor’s degree required. CPA license desired. Minimum one (1) to three (3) years experience in Medicare Part D and analyzing Pharmacy data. CMS Financial reconciliation experience is required.

Under the direction of the director of pharmaceutical services, the Medicare Part D analyst will be responsible for reviewing, understanding, and integrating processes related to Medicare Part D. The analyst will handle complex data projects, review regulations, and assist in project managing processes across departments. Duties related to this position include oversight of; support/ resolution of PDE claims, accuracy of eligibility data, transaction data, cross department communication, and meeting all regulatory requirements. Proficient in Microsoft Applications with the emphasis on Excel and Access. Ability to interpret detailed data and develop accurate, meaningful and reliable reports for management while meeting ongoing deadlines. Excellent written, organizational, data entry and interpersonal skills required.

NURSING INFORMATICS MANAGER
Master’s Degree or PhD in Nursing or related clinical field, with experience in statistics and an emphasis on quantitative analysis required. Health informatics certificate preferred. 2+ years of clinical data analysis experience in the healthcare industry or medical research area.

This position reports to the Director of Medical Operations, knowledge of healthcare data (preferably managed care / health plan data) required, including but not limited to membership, eligibility, claims, encounters, pharmacy, provider, and financial data. Knowledge of CMS Star Rating methodology, HEDIS measures, and HCC risk adjustment methodology preferred. Advanced skills in Microsoft Office, SQL, and Access required. Strong analytical and critical thinking skills required. Excellent technical, interpersonal, written and oral communication skills required. Experience with data mining tools preferred.

PURCHASING MANAGER
Bachelor’s Degree in Business or related field is required. Professional certification from a national body (e.g. ISM or NIGP) is preferred. A total of ten (10) years Purchasing experience, at least five (5) years supervisory experience. Governmental purchasing experience preferred.

CONTRACTS MANAGER
Bachelor’s degree required. Minimum of four (4) years experience in a managed care environment. Three (3) years of experience in a managed care environment, emphasis on Provider contracting. A minimum of two (2) years of direct experience in negotiating Provider contracts. A valid California Drivers License required.

Provider contracting and analytical skills with emphasis on time management, financial analysis, and problem solving. Microsoft applications (Microsoft Word and Excel required) for use in all aspects of an office environment. Thorough knowledge of contracting structures and payment methodologies preferred. Excellent communication, interpersonal and organizational skills.

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**Member Services Leadership**

Inter Valley Health Plan, a regional, not-for-profit, Medicare Advantage Plan with Part D benefit, headquartered in Pomona, California, has an opening for a Manager or Director of our Member Services area (title will be based on work experience). Reporting to the Vice President, Marketing and Member Services, the Manager or Director, Member Services is responsible for Medicare Member Services operations by planning, developing, managing, and motivating staff to optimize both individual and team performance. This position is responsible for ensuring that member calls are answered timely and with accurate member information with the overall objective of high touch customer service. The manager will audit, coach and train staff to guarantee high quality and seamless delivery of service. The Manager will utilize all measurement tools including, Speech Analytics, TASKE, FACETS and Call Manager to ensure effective employee performance. This position must have excellent written and verbal communication skills.

**Requirements Include:**

- College degree;
- must have excellent communication and presentation skills
- Must have approximately 4 years previous experience in our industry in a leadership role within Customer Service and know Medicare guidelines extremely well as well as interrelated State programs
- Strong experience with customer service interventions for training, measuring and developing staff through using various measurement
- Management experience in a Medicare Advantage plan is required, prior customer service experience in a consumer oriented business is a plus

**To Apply:** Please submit your resume with cover letter to: [jobs@ivhp.com](mailto:jobs@ivhp.com)

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California Health & Wellness is the first new Medi-Cal Managed Care Plan in California in nearly a decade. It is the California division of Centene Corporation (Centene) that has established itself as a national leader in the healthcare services field. Today, through a comprehensive portfolio of innovative solutions, we remain deeply committed to delivering results for our stakeholders: state governments, members, providers, uninsured individuals and families, and other healthcare and commercial organizations.

**Vice President, Compliance**

Ensure regulatory compliance with state and other government agencies related to the health insurance industry, Centene Corporation, and its business subsidiaries.

**Responsibilities:** Ensure business unit and Centene Corporate are in compliance with state, federal program/insurance regulations, regulatory and state contract requirements. Maintain, track laws, regulations, contract documentations, amendments, and compliance measures. Develop policies, procedures, processes to comply with state/federal law, contract requirements, and standards. Overseer, administer, and implement compliance programs, including fraud and abuse and HIPAA. Provide guidance to departments regarding compliance issues, implementation of new requirements.

**Education/Experience:** Bachelor’s degree in Public Policy, Government Affairs, Business Administration or related field. Master’s or Law degree preferred. 8+ years compliance program management, contract experience. Extensive knowledge of state administrative code, regulations, state insurance laws, regulations including managed care regulations. Experience with state/federal government agencies, accreditation bodies, participating provider agreements, HIPAA and Third Party Administration (TPA) laws, credentialing regulations and prompt pay laws.

Please submit your resume to JMERTZLUFT@CENTENE.COM

**Director, Medical Management**

Direct medical management program including utilization management, case management, quality improvement and credentialing in accordance with the mission, philosophy, and objectives of plan and in conjunction with Corporate goals and objectives.

**Responsibilities:** Develop department objectives and organize activities to achieve objectives. Evaluate and implement changes to medical service functions and performance in relation to company mission, philosophy objectives and policies. Manage budget and forecast for strategic planning and key initiatives. Coordinate with operating departments on research and implementation of best practices. Responsible for the statistical analysis of utilization data on programs. Participate in NCQA, State, and/or other accreditations of the Plan. Organize and present new concepts, programs and tools to staff and other plan departments. Develop communication plans with external providers such as hospitals and State agencies as required to facilitate plan goals and objectives. Coordinate with Medical Director to educate and communicate expectations with providers.

**Education/Experience:** Bachelor’s degree in Nursing, related field, or equivalent experience. 7+ years of nursing, quality improvement, and management experience in a healthcare environment, preferable managed care. Previous management experience including responsibilities for hiring, training, assigning work and managing performance of staff.

**License/Certification:** RN license.

Please submit your resume to BGLICK@CENTENE.COM

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