TOP STORIES

ICD-10 Transition Going Smoothly for California Providers

Few problems reported during October rollout

California providers reported few problems with the transition to ICD-10 in October and a minimal number of claim denials linked to coding errors.

“We’ve heard about a few issues with providers having claims rejected but nothing on a large scale,” said Molly Weedn, associate vice president of public affairs for the California Medical Association. “And the few instances we’ve heard about where there are coding issues, they’ve been resolved pretty easily between the physicians and insurers.”

There were a number of concerns in the run-up to ICD-10 and its more detailed system of codes. The primary concern was that providers would have multiple claims bounced back from insurers due to errors or unspecified codes. And while that’s happened to some degree, it hasn’t created widespread problems.

One the state’s largest medical groups, Brown & Toland Physicians, said there was “nothing really to report” in terms of problems with ICD-10 coding. “We did a lot of education with our doctors—more than a year’s worth—and the doctors on our EHR system had less to worry about since the system was updated to ICD-10 codes,” said Richard Angeloni, director of integrated marketing and communications for San Francisco-based Brown & Toland.

Other states are also having a smooth transition into ICD-10. Barbie Hays, coding and compliance strategist for the American Academy of Family Physicians (AAFP), said she’s heard about some problems but nothing widespread. “We’re not hearing about any catastrophes,” said Hays. “We’re hearing about some claims being rejected because they’re missing vital information or because they listed a condition as unspecified.”

Hays said concerns about the new coding system being too labor intensive for clinicians and physicians have been justified to some degree. “Before the launch of ICD-10, physicians were worried that they’d be up until 2 a.m. doing paperwork,” said Hays. “But from what we’re hearing, physicians are only taking an extra two or three minutes per patient [for paperwork].”

Hays added that some coding problems appear to be linked to certain electronic medical record systems. “We’re hearing that some EMR systems are not doing as well as others and that the whole claims process is taking longer,” said Hays.

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ICD-10 Transition cont.

Both the CMA and AAFP credit a yearlong program of training and testing leading up to the rollout of ICD-10 for the smooth transition. "We did a lot of work with our members leading up to the transition and that work seems to have paid off," said Weedn.

The Centers for Medicare & Medicaid Services (CMS) reported that only 10.1% of Medicare and Medicaid claims were denied during the first four weeks of October, just slightly more than the average rate of 10% of claims denied in a typical month.

"CMS has been carefully monitoring the transition and is pleased to report that claims are processing normally," CMS said in a statement. "During the first four weeks of October, 2% of all claims were rejected due to incomplete or invalid information and less than 1% were rejected due to invalid ICD-10 coding."

The California Department of Health Care Services (DHCS) said it’s rejected a minimal amount of claims due to ICD errors since October 1. "DHCS has determined that an average of less than 1% of claims are being rejected for ICD-10-related errors," said DHCS spokesperson Carol Sloan. "The errors on the rejected claims are due to providers billing by using an incorrect code set or an incorrect ICD-10 indicator." She added that provider calls and questions regarding claims in October “have been consistent with historical baseline data.”—DOUG DESJARDINS

State Fines Blue Shield and Anthem for Provider Directory Errors

Insurers reimbursing members for out-of-network costs

The California Department of Managed Health Care (DMHC) fined Anthem Blue Cross and Blue Shield of California for inaccuracies in their provider directories.

The DMHC fined Blue Shield $350,000 and Anthem $250,000 for mistakes uncovered during a 2014 state survey of directories for plans sold on Covered California. The survey found that 8.8% of providers listed in Blue Shield’s provider directory were not accepting patients for Blue Shield’s Covered California plan and that 12.8% of physicians listed in Anthem’s directory were also not accepting patients.

"An important element of access is ensuring enrollees have accurate provider directories," said DMHC director Shelley Rouillard. "The DMHC has taken enforcement action and fined Blue Shield and Anthem due to unacceptable inaccuracies in their directories." DMHC spokesperson Rodger Butler said Blue
request for arbitration was an attempt to avoid having the lawsuit tried in open court. The UFCW also alleges that "Sutter's anti-competitive behavior has caused healthcare prices to be higher in Northern California than in Southern California."

■ Contra Costa Health Services (CCHS) has partnered with local police departments for a new program that will take a proactive approach to helping people with mental health issues who have repeated contact with police. The CCHS Mental Health Evaluation Team (MHET) includes three mental health clinicians from the CCHS Behavioral Services Department and one officer each from police departments in Concord, Richmond, and Pittsburg. When police encounter people with suspected mental health issues in the field, they can refer the cases to MHET for follow-up. "MHET helps break a cycle of crises for people who are in frequent need of emergency services because of mental illness," said Cynthia Belon, the director of Behavioral Health Services for CCHS. "It provides an avenue for treatment that they might not otherwise be able to access."

■ Covered California launched a new ad campaign with the tagline "It's not just health care - it's life care" to promote the current open enrollment period that began on November 1. The $29 million TV, radio, and Internet marketing campaign is airing in English, Spanish, Mandarin, Cantonese, Korean, and Vietnamese across the state.

Shield received a larger fine than Anthem "because of Blue Shield's lack of cooperation in the investigation" of provider directory inaccuracies.

The survey also found that 18.2% of providers listed in Blue Shield's directory were not at the address listed in the directory and the same was true for 12.5% of physicians listed in Anthem's directory. Rouillard said the mistakes "limited enrollee access to care that resulted in an unacceptable consumer experience and must be fixed."

Blue Shield and Anthem are also in the process of reimbursing policyholders who were billed out-of-network fees for going to providers listed as in-network in their provider directories. The DMHC said that Blue Shield "has already reimbursed more than $38 million to enrollees who incurred out-of-network costs" but that it doesn't have a total for reimbursements distributed by Anthem.

Rouillard said Blue Shield and Anthem "will report to the Department the final number of enrollees reimbursed and the total amount reimbursed." Both insurers have until October 1, 2016 to reimburse affected policyholders and report final numbers to the DMHC.

Anthem Blue Cross spokesperson Darrel Ng said Anthem has corrected the problems that led to the mistakes in provider directories. "During this time of unprecedented change and despite Anthem's continual efforts to improve the accuracy of the system, Anthem's provider directory inadvertently listed some providers," said Ng. "In the last two years, Anthem has spent more than $4 million improving the provider directory to make it more user-friendly and improve the accuracy of the data."

Blue Shield said the agreement with DMHC "is in the best interests of our members" and that "the settlement addresses past issues raised in 2014, and our members should not be concerned about their current plan or its network."

When the results of the state survey were released in November 2014, both Blue Shield and Anthem said they had issues with the way the state conducted its survey of provider directories by telephone and contended that many providers who said they weren't part of health plans actually had contracts with them.

The provider directory problems led state lawmakers to approve legislation this summer that will require insurers to update their provider directories on a weekly basis starting in 2016. Senate Bill 137 authored by Ed Hernandez (D-West Covina) will also require providers to list languages other than English that are spoken by a physician or staff members.—DOUG DESJARDINS
"Reaching California's diverse population is critical," said Covered California executive director Peter Lee. "This year, we are spending more than we ever have on a monthly basis to promote coverage and enrollment." Covered California expects to enroll up to 390,000 uninsured state residents for coverage during the open enrollment period that ends January 31, 2016.

Several California health systems were among 457 hospitals in 43 states that paid more than $250 million to settle a whistleblower lawsuit regarding cardiac devices implanted in violation of Medicare requirements. According to a November 1 report in the Los Angeles Times, Irvine-based St. Joseph Health System and 10 affiliate hospitals agreed to pay $2.7 million as part of the settlement. Sacramento-based Sutter Health agreed to pay $3 million. San Diego-based Scripps Health also agreed to pay $5.6 million on behalf of its five hospitals. The settlement ended a four-year investigation by the U.S. Department of Justice into hospitals that were allegedly billing Medicare for unnecessary implants of implantable cardioverter defibrillators, which cost up to $40,000. In all, 27 California hospitals were part of the settlement.

The California Fourth District Court of Appeal on October 29 affirmed a lower court ruling to dismiss a lawsuit that sought to allow physicians in California to assist terminally ill patients with voluntary euthanasia. The court upheld a lower court ruling that dismissed the lawsuit on the ground that the state's medical malpractice law bars lawsuits against physicians who assist patients in voluntary euthanasia.

The California Franchise Tax Board decision to treat Blue Shield of California as a for-profit insurer was appealed by the insurer. The ruling would cause Blue Shield to pay millions in federal taxes since its appeal of the FTB ruling is continuing. The FTB decision will also require Blue Shield to pay millions in state taxes. Blue Shield of California has filed a petition for judicial review of the FTB decision, and the state is scheduled to file a response by August 2016. The Franchise Tax Board decision will also require Blue Shield to pay millions in state taxes.

For Kaiser, which has approximately 100,000 members in the Stockton area, the venture provides those members with another destination for care. Kaiser also contracts with 200-bed Dameron Hospital in Stockton for inpatient care. "Kaiser has a very distinct business model but it also cannot necessarily afford to build its own hospitals in every part of the state, so this type of collaboration allows them to expand in markets without major capital investments," said Kominski.—DOUG DESJARDINS

**TOP STORIES**

**Dignity Health and Kaiser to Jointly Own Stockton Hospital**

Health systems to operate St. Joseph's Medical Center

Dignity Health and Kaiser Permanente have agreed to enter a joint venture to own and operate a hospital in the city of Stockton.

Under the agreement, Dignity Health will retain an 80% ownership stake in St. Joseph's Medical Center and Kaiser will acquire a 20% interest. The deal is expected to close by the summer of 2016 and marks an unusual partnership between two of the largest health systems in California. Financial terms of the deal were not disclosed.

"We look at this as a real opportunity to serve our community," said St. Joseph's Medical Center president and CEO Don Wiley. "We look forward to welcoming Kaiser Permanente members and physicians."

While Dignity Health will maintain responsibility for day-to-day operations at St. Joseph's, the 366-bed hospital will be governed by a joint board of directors with four Dignity board members and three Kaiser board members. Kaiser physicians will join the medical staff at St. Joseph's and provide care for Kaiser health plan members treated at the hospital.

Under the deal, St. Joseph's Medical Center will retain its name and launch a project to expand its emergency department by 50%. The joint venture will also give Kaiser a 20% ownership stake in St. Joseph's Behavioral Health Center.

"Both St. Joseph's Medical Center and Kaiser Permanente have a long record of service to the Stockton-San Joaquin area and we believe this is a great opportunity to learn and innovate together," said Kaiser Permanente senior vice president and Central Valley Area manager Deborah Friberg.

Analysts say the deal make sense for both Dignity Health and for Kaiser, which doesn't own a hospital in the Stockton area.

"Joint ventures by definition provide mutual benefits, so from Dignity's perspective, giving away a small share of this hospital may provide access to capital and ongoing operating expenses," said Gerald Kominski, director of the UCLA Center for Health Policy Research. "Kaiser is a stable partner with patients who are privately insured, so Dignity automatically increases its market share in this hospital."

For Kaiser, which has approximately 100,000 members in the Stockton area, the venture provides those members with another destination for care. Kaiser also contracts with 200-bed Dameron Hospital in Stockton for inpatient care.

"Kaiser has a very distinct business model but it also cannot necessarily afford to build its own hospitals in every part of the state, so this type of collaboration allows them to expand in markets without major capital investments," said Kominski.—DOUG DESJARDINS
ill patients to end their own lives. The lawsuit was filed in May 2015 by three terminally ill patients and contended that California law did not specifically prohibit physician-assisted suicide. In his ruling, Associate Justice Alex McDonald wrote, “We believe prescribing a lethal dose of drugs to a terminally ill patient with the knowledge that the patient may use it to end his or her life goes beyond the mere giving of advice and encouragement and falls under the category of direct aiding and abetting.” The plaintiffs’ attorney, John Kappos, said he may appeal the decision to the California Supreme Court.

Alecto Healthcare Services has been selected to provide management services for Antelope Valley Hospital and the Antelope Valley Healthcare District (AVHD). The AVHD board chose Alecto from a group of two CEO candidates and another hospital management firm. Alecto will handle management services for the healthcare district and 420-bed Antelope Valley Hospital in Lancaster but the AVHD board will continue to be in charge of decision making. “Each hospital is unique and presents a different set of challenges, but the solution always involves a strong commitment to the hospital employees, physicians, and patients,” said Alecto CEO Lex Reddy. “Our commitment is not only to the hospital but to the community and its healthcare needs.”

A California physician was convicted of second-degree murder for the deaths of three former patients who overdosed on prescription drugs she prescribed. According to an October 31 report from the Associated Press, Hsiu-Ying Tseng, MD, was also convicted of illegally writing prescriptions for two of the deceased patients and 16 other people including two undercover agents who were investigating Tseng for prescribing large amounts of pain medications to patients at her Rowland Heights medical clinic. Los Angeles County deputy district attorney John Niedermann said the verdict demonstrates that “you can’t hide behind a white lab coat and commit crimes.” Tseng’s attorney said the verdict was “disappointing” and doesn’t “bode well for doctors in America.”

CalOptima will provide free flu shots and health screenings at its annual Health and Wellness Community Event on November 14 at its corporate headquarters in Orange. The 20th annual event will provide free screenings for blood pressure, glucose, cholesterol, and body mass index for adults and free vision and dental screenings for children in addition to free flu shots. “For the past 20 years, CalOptima has provided access to quality healthcare for Orange County’s low-income residents,” said CalOptima CEO Michael Schrader. “Many of our partners are participating in this event with us, showcasing again our shared dedication to strengthening local healthcare.”
Chief Operating Officer (Coo)

CalOptima is a county organized health system that administers health insurance programs for low-income children, adults, seniors and people with disabilities in Orange County, California. Our mission is to provide members with access to quality health care services delivered in a cost-effective and compassionate manner.

CalOptima has an open position for Chief Operating Officer. The COO serves as a member of the executive team and contributes to strategic planning for the organization. This position has the authority and accountability to lead CalOptima according to the strategic plan, goals and objectives. The COO has direct responsibility for Information Services, Operations, New Program Implementation, and the Executive Directors who have oversight of these areas.

**Position Responsibilities:**

- Related to Operations, the COO oversees Claims, Customer Service, Project Management, Grievances & Appeals, Coding Initiatives, Business Integration, Process Excellence and Information Services. This position is accountable for managing cross-organizational collaboration for agency-wide projects and initiatives, ensuring that operations perform effectively and deliver results and metrics.
- Related to Information Services, the COO oversees Systems Development and Applications Management, including configuration, integration and ongoing operations.
- Related to New Program Development, the COO is responsible for the organization-wide implementation of major new programs and initiatives. This requires strong leadership skills with the ability to influence and manage, the capacity to quickly understand all major functions within the health plan, and the skill to prioritize competing demands.

**Required Skills:**

- Strong interpersonal skills, including excellent verbal and written communication skills.
- Strong leadership skills, with the ability to influence and manage.
- Strong management skills, including prioritization of concurrent projects.
- Strong problem-solving, analytical and organizational skills, with attention to detail.
- Appreciation of cultural diversity and sensitivity toward target population.

**Experience & Education**

- At least 7 years of managed-care operations or IS experience at an executive level.
- Prior experience as a COO, CIO or position of similar responsibility preferred.
- Background in government programs.
- Experience giving reports to a Board of Directors, member and provider advisory groups.
- Relevant Bachelor’s degree; Master’s degree desirable.

**Candidates Required Qualifications:**

- Bachelor’s Degree in Business, Public Administration or similar
- At least eight years progressively responsible leadership positions in healthcare and/or insurance settings, which includes oversight of network development, contracting, and provider services/operations; and
- At least five years supervisory experience.
- In-depth knowledge of the principles and practices of network development and contracting, including provider reimbursement methodologies.
- In-depth knowledge of the health care industry, its critical issues and major challenges.
- In-depth knowledge of health care delivery systems as they relate to assigned areas of responsibility.
- In-depth knowledge of operations best practices and metrics, and ability to utilize them to obtain desired results.
- In-depth knowledge of regulatory guidelines as they relate to assigned areas of responsibility.
- Very strong negotiation skills, including a demonstrated ability to negotiate complex service levels and rates.
- Very strong collaboration skills, with demonstrated ability to create and foster a collaborative work environment, maintain effective, high performance teams, and organize people and resources to solve problems and identify business opportunities.

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

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- Director, Government Relations
- Executive Administrative Assistant
- Manager, Claims Transaction

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)

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- Hospital & Physician Alignment
- Medical Group Management, Performance Improvement & Physician Compensation
- Population Health Management & Value-Based Purchasing
- Valuations & FMV Opinions
- Strategic Business Planning

We are currently seeking healthcare leaders who have extensive experience and expertise in the following areas:

- Medical Group Management & Performance Improvement
- Service Line Financial & Operational Performance
- Healthcare Financial Analysis
- Valuations & FMVs
- Population Health Data Analytics

MDS is seeking to fill positions at various levels, including: Principal, Manager, and Senior Consultant.

Qualified candidates should thrive in a collaborative, team-based environment, and possess superb analytic, writing, and communication skills.

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L.A. Care occupies a leading position in the managed health care field in California and is the largest organization of its kind in the U.S. - a publicly operated health plan with over $6 billion in revenues. Based in Downtown Los Angeles, its unique mission is supported by a staff passionate about making a difference in the lives of the most vulnerable individuals in Los Angeles County. L.A. Care offers an exciting environment with considerable opportunities for professional and personal growth and a generous array of employee benefits.

L.A. Care is seeking four dynamic, highly experienced product line executive leaders to oversee L.A. Care teams responsible for providing the highest quality care to over 1.8 million Los Angeles County residents. Each product line Executive Director is a senior member of the executive team and will lead a seasoned group of committed managed health care professionals and apply his or her experience with either state-sponsored or commercial programs to help build a healthier L.A. Each will be responsible for the overall operational and financial performance of their product line and for ensuring a well-run and administratively capable organization. Product lines are segmented as follows:

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DIRECTOR OF CARE MANAGEMENT
This position reports to the Sr. Director of Care Management. Current unrestricted California RN License; BSN required and Masters Degree in Nursing preferred or comparable experience. Possession of a valid California Drivers license and valid automobile insurance. CCM certification a plus. At least three to five years as a registered nurse in a clinical setting; and at least 5 years progressively responsible experience in Care Management in a managed care setting.

Operational knowledge of computer applications in an office environment. Knowledge of CMSA professional standards.

DIRECTOR PROCESS IMPROVEMENT
Bachelor’s degree required, preferably with an emphasis in a Technical Science or Engineering. Masters degree in Public or Business Administration preferred. Certified Professional in Healthcare Quality preferred. Certified Lean Six Sigma Black Belt or Master Black Belt preferred. Minimum of ten (10) years performance management and quality improvement experience with an emphasis on Lean/Six Sigma methodologies required. Proven skills adapting and applying Lean Six Sigma methodologies, performance management and quality improvement in a public health setting. Demonstrated understanding of business principles, strategy, technology processes and operations with an inherent ability to apply technology in solving business problems. Strong leadership, communication, written and interpersonal skills to execute and manage activities in a fast paced environment. Ability to establish and maintain effective working relationships at all levels within the organization.

Ability to exercise discretion and independent judgment, make decisions and must possess strong analytical skills. Ability to influence management and create positive change, as well as gather data, perform analysis, recommend courses of action for greater productivity independently. Must have ability to perform research and analysis in support of company inquiries and modify and enhance the modeling effort to accommodate new processes, procedures, products and services. Position requires an individual who is extremely organized with excellent written and verbal communication skills and ability to establish and maintain effective working relationships. Must have the ability to model concepts and to access and manipulate data through self-system access and personal analysis.

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.

FINANCIAL ANALYST
Bachelor’s degree required. Minimum three (3) years of Finance experience. Experience and knowledge of complicated budgets preparation and budget to actual analysis in Excel. Experience in Managed Care preferred.

Strong knowledge and demonstrative proficiency utilizing Microsoft Applications (Word, Excel, Access & PowerPoint). Strong understanding of accounting and financial principles and methodologies and attention to detail. Experience with Oracle or Hyperion a plus. Principles and practices of health care industry and strategies, health care systems, and budget modeling and forecasting.

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.

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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.

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.

RISK ADJUSTMENT INFORMATICS MANAGER
Bachelor’s degree in a health-related field required, Master’s preferred. Will accept five (5) years related work experience in lieu of education requirement. AHIMA or AAPC Certified Coder preferred. Possession of a valid California Drivers license and valid auto insurance. Four (4) or more years experience in Medicare Managed Care Plan Reporting, Medicare (RAPS)/HCC Informatics at a Health Plan. Strong data analysis experience, specifically in the areas of risk adjustment.

AHIMA or AAPC Certified Coder with experience in managed care, program/project management, data analysis and interpretation. Working knowledge of Medicare RAPS/HCC programs and CMS HCC coding requirements for Medicare Advantage and Part D plans. Excellent written and verbal communication and interpersonal skills, ability to establish and maintain effective working relationships with others, strong critical thinking skills required, ability to demonstrate sound analytical reasoning.

HCC CODING SPECIALIST
AHIMA or AAPC Certified Coder (CPC license). RN or LVN issued by the State of California required. Two (2) years experience in HCC Coding in an HMO setting is preferred. Must have strong chart audit experience in HCC Coding.

Experience in managed care, program/project management, data analysis and interpretation. Working knowledge of Center for Medicare & Medicaid Services (CMS) HCC coding requirements, ICD-9 and CPT guidelines are required. Knowledge in HCC-Risk Adjustment process and health insurance concepts as they relate to Medicare Advantage and Part D plans is required. ICD-10 coding certification preferred. Ability to take general direction and manage complex projects within deadlines. Excellent written, oral, and presentation skills. Proficiency in Microsoft Word, Excel, and other computer applications. Valid State of California license and insurance.

PHARMACY PDE MANAGER
Bachelor’s degree in accounting, finance or equivalent is preferred. Minimum one (1) - three (3) years experience in Medicare Part D and analyzing pharmacy data. CMS Financial reconciliation experience is preferred. PDE experience is required.

Proficient with Microsoft Office Products with the emphasis on MS Excel, SQL, and MS Access. Experience in MARx, pharmacy claims systems and accounting general ledgers is a plus. 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 is required. Able to handle multiple demanding tasks. Ability to work and make independent decisions, maintains confidentiality, be an effective communicator and work with other team members. Capable of working with minimal supervision. Ideal candidates must have strong problem solving abilities.

MEDICARE CLAIMS PROCESSOR
Possession of a High School Diploma or equivalent. Three (3) years experience in adjudicating medical claims; professional and institutional preferably in an HMO or Managed Care setting; Medicare/Medi-Cal experience preferred.

Microcomputer skills, proficiency in Windows applications preferred. ICD-9 and CPT coding and general practices of claims professing. Professional demeanor, excellent communication and interpersonal skills, strong organizational skills required.


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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.

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- Case Manager P/T & Per Diem
- Manager, Coding Compliance
- OP Ancillary/Physician Coder
- Supervisor, Credentialing
- Medical Management Coord. (Seaside)
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INFORMATION SERVICES
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Physician Network Development Manager
Encino & Beverly Hills, CA

This position will take on a lead role in building Cedars-Sinai’s HMO provider network in strategic markets poised to accept HMO, PPO and Medicare patients. Involves partnering with the Director of Network Development to build a high quality, integrated delivery network while focusing on developing relationships with and recruitment of PCPs, specialists and ancillary providers. The successful candidate will have the expertise required to research/maintain market intelligence on the managed care provider landscape, analyze complex business proposals and identify optimal solutions. Requires a BA/BS degree with 5+ years of healthcare industry experience, preferably within a managed care setting. MS degree in Public Health or Health Services Administration preferred.

In addition to professional development opportunities, Cedars-Sinai offers a competitive compensation and benefits package. For more information or to apply, visit us online at: https://www.cedars-sinaimedicalcenter.apply2jobs.com/ and reference Req #M10579.

cedars-sinai.edu/careers

Cedars-Sinai is an Equal Opportunity Employer that welcomes and encourages diversity in the workplace. EEO/AA/F/Veteran/Disabled

Cerner is continuously building on our foundation of intelligent solutions for the health care industry. Our technologies connect people and systems at more than 14,000 facilities worldwide, and our wide range of services support the clinical, financial and operational needs of organizations of every size. Cerner has partnered with Adventist Health to manage their Revenue Cycle Departments. Cerner is currently seeking qualified candidates for the following positions:

**California**
- Revenue Supervisor Roseville
  - Req# 15176BR
- Director of Case Management Paradise
  - Req# 11874BR
- Patient Financial Services Director Glendale
  - Req# 15358BR
- Home Care Patient Financial Services Manager Roseville
  - Req #15208BR
- Regional Coding Manager Hanford
  - Req# 15130BR
- Patient Financial Services Manager Santa Rosa
  - Req#14622BR
- Compliance Manager Roseville
  - Req#15115BR

**Oregon**
- Director of Case Management Portland
  - Req# 15372BR

**Hawaii**
- Patient Access Team Lead Kailua
  - Req# 13716BR

To review a complete description and apply, search for the relevant req. number at: www.cernerjobs.com
FEATURED CAREER OPPORTUNITIES

Cedars-Sinai Health Associates is SEEKING A MEDICAL DIRECTOR to join its team in Beverly Hills, California.

At Cedars-Sinai Health Associates (CSHA), an IPA within the Cedars-Sinai Medical Network, our medical professionals bring everything they have in order to provide the highest caliber of care to our patients. It’s because of their compassion, their expertise, and their dedication that Cedars-Sinai Medical Network is consistently recognized for its quality and service. We’re currently seeking a talented Medical Director who shares our same outlook to join the CSHA team.

As an invaluable part of the Cedars-Sinai Medical Network, our CSHA Medical Director is responsible for providing senior leadership to a large network of individual physicians with independent offices throughout Los Angeles. These physicians have come together to form an independent physician association (IPA) to serve the community’s managed care medical needs. This position works collaboratively with the CSHA Board of Directors and administrative leadership of Quality, Clinical Efficiency, Care Transitions and Medical Group Operations to achieve mutual goals for the organization.

Requires current CA medical license and Board certification in one of the following specialties: Internal Medicine (preferable), Family Practice (preferable), Pediatrics, Internal Medicine Sub-specialty.

Learn more and apply by visiting www.cedars-sinaimedicalcenter.apply2jobs.com and reference Req #M10378.

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

COMMUNITY HEALTH WORKER Req. #15-1951
ENCOUNTER DATA SPECIALIST – REPORTING Req. #15-1769
ENCOUNTER DATA SPECIALIST SR. – REPORTING Req. #15-1904
GRIEVANCE & APPEALS COORDINATOR Req. #15-1976
HEALTHCARE ANALYST SR. Req. #15-1919
HEALTHCARE INFORMATICS ANALYST II Req. #15-1979
NETWORK MANAGEMENT SPECIALIST Req. #15-1891
PART TIME NURSE PRACTITIONER (STOCKTON, CA) Req. #15-1963
PHARMACY ANALYST Req. #15-1739
PROJECT MANAGER Req. #15-1969
PROJECT MANAGER – HCI Req. #15-1863
PROJECT MANAGER – PHARMACY Req. #15-1907

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EEQ/A/A/F/Veteran/Disabled
St. Joseph Heritage Healthcare is now hiring for the following position:

**EXECUTIVE DIRECTOR, NETWORK SERVICES**

The Executive Director, Network Services is responsible for monitoring and managing physician relationships within our Southern California Networks. The position will assist the Vice President, Affiliated Networks with network development, profitability and management in an effort to support the needs of the Provider Networks. In addition, the ED will act as a liaison of the St. Joseph Heritage Healthcare Affiliated Physicians pursuant to such Provider Relations/Operations or Business Development strategies sanctioned or sponsored by St. Joseph Hospital and/or St. Joseph Heritage Healthcare, and the implementation thereof. In this role the ED will be directly responsible for the St. Joseph Hospital (SJHAP) and Hoag Affiliated Physician (HAP) networks. In addition, the ED will have oversight and responsibility for the remaining Southern California affiliated networks at Mission Hospital (MHAP), St. Jude Hospital (SJAP) and St. Mary’s (Premier Physicians) and their corresponding staff.

**Qualifications:**

**Education:** Requires a Bachelor's Degree in Business Administration, Healthcare Administration, or related field.

**Experience:** 7+ years Provider Relations experience within ambulatory, medical group, IPA setting required. 7+ year’s leadership experience within healthcare. Solid understanding of Per Diem, Capitated, Fee-for Service and Case Rate contracts.

Submit your resume to Carissa.lopez@stjoe.org