Oneise Morera

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SUMMARY

Proven and effective leader with over 25 years of experience in healthcare plan management. Significant experience in consumer analytics, business processes, CMS Regulatory Compliance, MA-PD Enrollment & service center operations, training & quality improvement. Experienced with initiating and executing small to large size projects, driving delivery and ensuring results.

PROFESSIONAL EXPERIENCE

Senior Business Analyst/Product Owner, Invidasys, Inc. November 2019 – Present

- Participate in successful consulting engagements with our clients relating to improving the operational performance as it relates to their current software platforms and identifying areas where the software may be able to develop complimentary solutions.
- Conduct process analysis, process evaluation and implement process improvements.
- Analyze data/reports to validate quality of information, identify trends, highlight patterns, define inconsistencies and summarize/present findings and results.
- Provide project status and escalate issues to management when necessary.
- Set expectations concerning operational improvement, deliverability, and cost of the project; periodically check status of project with client and team to assess project against plan.
- Assist in estimating timeframe, quality and quantity of resources required to successfully implement project; monitor and adjust for budget and schedule variances of entire project.
- Participate in on-site planning and requirements gathering and clarification sessions with clients.
- Analyze business requests and develop business requirements and systemic solutions.
- Communicate and translate concepts to both business and technical personnel.
- Development of designs for modifications to existing software components or for creating new components that work in concert with the existing Framework.
- Document user stories, business logic, customer workflows, use cases and prototype specifications and share with the Product Development team
- Assist as needed with QA, application support for hosted clients and our product support group.
- Participation in the evaluation of new technologies and platforms as needed.

Director of Operations, HealthSun Health Plans**,** Inc. May 2017 **–** November 2019

- Responsible for developing and executing strategic project plans for the successful implementation of new operational processes of the G&A, Enrollment and Customer Service for a 5 Star Medicare Advantage Plan
- Work closely with department managers to ensure they have the resources and tools in place to manage and monitor their staff in a consistent and effective manner
- Responsible for production/quality results of over 50+ employees in 4 different 0perational areas (Appeal & Grievances Department, Member Services, Provider Inquiry, and the Enrollment Department)
- Implemented resource management plans to restructure departments to include Auditors and Trainers in each area to ensure quality and continuous education based on employee quality results.
- Presented market studies to increase employee compensation to industry standard.
- Work with the teams on defining success criteria and system enhancements to develop reports for Operational Metrics, ODAG and CDAG Universe Reviews, Call Log Audits, and Data Validation reporting to CMS.
- Responsible for developing and maintaining performance and call quality metrics, ensuring staff is continuously being assessed, trained and educated.
- Responsible for shifting the Grievance intake to the Member Services Department as opposed to directly to the Grievance Unit, this improved the first call resolution by 30%
- Significantly improved Provider Inquiry call center metrics by working with subject matter experts to maximize efficiency, by understanding challenges and streamlining processes.

- Improved employee turnover and employee morale by successfully executing a rewards and recognition program.
- Established Service Operations Team meetings where the Managers, team leads, and auditors can communicate in an organized fashion about agenda items that impact the service operations teams.
- Ensure that Managers and leaders hold bi-weekly meeting to discuss department updates, changes and results.
- Monitor the continuous reviews of policies and procedures to determine adequacy of process, process changes, level of understanding and the quality of the processes.
- Maintain working relationships with the Utilization Management Department to make sure callers have access to the organization determination process, The Part D Department to ensure Coverage Determinations are handled timely, Provider Services to ensure providers are educated in accordance with the provider contracts, Claims Department to ensure claims are adjudicated appropriately.
- Monitor all employee disciplinary actions and escalations, including hiring, promotions, terminations, salary increases, employee yearly evaluations, merit increases and Performance Improvement Plans (PIP).
- Work with Compliance to ensure compliance issues are reported in a timely manner and monitored.

Product Owner, Invidasys, Inc. February 2014 – May 2017

- Provide on-site planning services and requirement specification consultation to clients, giving recommendations for improving operational performance of current software platforms and identifying and implementing Invidasys solutions.
- Ensured that contract deliverables were met by assigning roles and responsibilities to team members while remaining accountable for the execution.
- Constantly identifying gaps in processes and informing clients of risks and possible solutions
- Liaison between the business and Development team to ensure mutual understanding of requirements and expectations.
- Create test scenarios and develop test plans to be used in testing the business applications to validate that the business requirements are incorporated to the system successfully.
- Manage tasks carefully by prioritizing tasks on JIRA and working closely with the development team to work on solutions and execute Sprints successfully, including end to end and regression testing.
- Develop software training documents, features and functionality documents and release notes prior to releasing Sprint content to client Support clients with post deployment testing and validation.
- Facilitate classroom style post deployment training on configuration and software functionality.
- Facilitate monthly meetings with clients to provide them with updates on day-to-day activities as well as Sprint content and roadmap progress.
- Lead effort to incorporate MAPD enrollment processing functionality to VIDABility, this goal was accomplished in 3 months for QNXT client who had manual MA processing because QNXT could not support.
- Develop Demo presentations and Demo the software to prospective clients.

Director of Eligibility and Enrollment, Simply Healthcare Plans, Inc. January 2011 – February 2014

- Managed and coordinated the overall activities associated with membership, including enrollment reconciliations that impact financials, such as Medicaid Flags, Hospice, Institutionalized individuals, and Risk scores.
- Managed and monitored the production of daily application data entry on EAM, BEQ processing, rejections, RFI, OOA flags, and daily batch submissions via Gentran.
- Compiled reports for CMS and Quarterly Reporting; aggregated data for discrepancy reports and weekly rejections
- Monitored yearly changes on chapter 2 required letters Managed letter approval process via Compliance and technical teams all the way through to testing and Production; managed and processed member communication letters based on TRR/TRC's.
- Achieved 100% LICS match rate by developing an intense pre-scrub process to minimize LICS level errors on PDE reports.
- Responsible for managing and ensuring a successful implementation of external vendor systems with CMS and legacy systems interfaces.
- Established, updated, and managed department policies, procedures, communication, and training systems to ensure departmental requirements were effectively met.
- After failed audit in the customer service area, the OEV department was moved to the Enrollment Department where I managed, monitored and reported on the Outbound Verification process we achieved.
- Managed, monitored and rectified the Outbound Verification process, achieving 98% of expected goal by the second reporting quarter after OEV Department was moved under my management.
- Responsible for managing fulfillment of post enrollment materials, such as ANOC, EOC, ID Card and OTC information
- Managed activities of the Enrollment staff, including hiring and PTO, helping them prioritize and keep on track through coaching, yearly evaluations, and corrective action.

- Met with senior level internal and external executives and other governmental agencies to resolve problems and implement resolutions Worked with QI to identify trends and improve processes.
- Experienced in mapping bids to benefit plan structures for ID card development and OTC programs.

Manager of Eligibility and Enrollment, Jackson Health Plans, Inc. January 2010 – August 2011

- Maintained and monitored enrollment maintenance processing for multiple lines of business, including, but not limited to, Employer Groups (Public Health Trust, Miami Dade Employees), COBRA, Medicaid plans (SFCCN, HMO, CMS), Medicare Advantage Plans (JHP For Life, Success, and Secure), and Individual plans (Cover Florida) Reconciled all membership data for all lines of business.
- Managed and maintained successful business relationships with numerous benefit administrators, service providers and Government entities such as FBMC, Metro Dade County, Medco, CMS, AHCA and Beacon (TPA)
- Managed Transaction Reply Reports (TRR) files including, but not limited to, accepted enrollments, disenrollments and change transactions Monitored and reviewed transactions daily to reconcile plan data and ensure accurate payment Monitored and audited the pre- and post-CMS member correspondence.
- Evaluated and identified prescription drug event (PDE) discrepancies to adjust and process PDP claims successfully through Palmetto/CMS Evaluated and identified Financial Information Reporting (FIR) rejections, submitting proxy forms to Relay Health and report corrections Managed Pre-edit reports to identify discrepancies with eligibility files provided to PBM.
- Identified and analyzed (834/flat files) file transfers, researching any discrepancies to provide recommendations and resolutions to findings Successfully placed interventions to minimize errors and increase customer satisfaction.
- Represented the Enrollment Department at intradepartmental meetings such as the Medicare Operations committee, PBM Operations Committee, Compliance Committee, etc. Played a vital role in the continuous training and education of the sales and marketing team.
- Managed the Outbound Education Verification (OEV) process for Medicare Beneficiaries Managed and monitored Medicaid newborn enrollment process and Compliance of ID Card/enrollment welcome kit mailings for the Medicare and Medicaid LOB
- Directly supervised work of the Enrollment Specialists, where my responsibilities included providing them the necessary guidance to successfully execute their daily responsibilities Provided my team with continuous guidance and conduct their monthly, quarterly, and yearly evaluations as necessary

Operations Supervisor, United Healthcare of Florida

November 1993 – December 2009

- Responsible for Development of Quality Improvement Program, including monitoring of phone calls for over 400 Customer Service Representatives, reporting trend analysis, and identifying areas of opportunity for call center improvement.
- Supervised 11 employees in three different business functions responsible for monitoring and stabilizing quality of service and compliance levels of Senior Market Customer Service Center (Medicare Advantage)
- Developed Medicare Modernization Act (MMA) Policies and Procedures Manual, MMA Training Module, and all needed tools these included assessment tools to determine customer service staff knowledge level.
- Handled data gathering and reporting of metrics.
- Conducted internal monitoring related to both Informal Grievances and HIPAA Compliance reported both results and corrective action plans translated Spanish grievances into English Prepared department for Corporate Health Plan Assessments and CMS site visits.
- Partnered with quality improvement teams to assist in areas such as study design, data collection validity, data analysis, and effectiveness measurements.
- Functioned as liaison between Medicare Customer Service Department and other contracted vendors such as pharmaceuticals and not-for-profit agencies Served as triage point for members, while coordinating with other staff to develop best possible resolution resolved issues involving access to care, claims, benefits and eligibility.
- Conducted seminars, including New Member Orientations, Member Forums and Wellness Seminars Represented Medicare Complete in seminars provided to members for health awareness Involved in projects for Medicare Member Outreach, Enrollment and Marketing, contacted over 2500 members quarterly regarding updates and plan changes.
- Managed outbound call campaigns to at risk enrollees to resolve issues and ensure enrollee satisfaction Contacted disenrolled members to track and trend dissatisfaction indicators thus producing significant data elements to determine areas of opportunity to improve the customer experience.
- Met goals included a decrease in annual disenrollments, an increase in customer satisfaction scores and a reduction in customer service complaints Partnered with internal focus groups in the creation and implementation of member outreach & education programs Able to reach retention and sales goals through strong community-based provider relationships,

knowledge of products and services offered.

ADDITIONAL EXPERIENCE

Call Center Operations Supervisor	2004 – 2009
Quality Improvement/Compliance Supervisor	2003 – 2004
Quality Improvement Analyst	2002 – 2003
Continuous Quality Improvement Administrator	2001 – 2002
Medicare Consultant/Quality Improvement Auditor	1998 – 2001
Personal Service Representative	1997 – 1998
Patient Relation Coordinator	1993 – 1997

RELEVANT SKILLS

- Microsoft Office Suite
- JIRA software
- EAM Balsamiq software
- QNXT
- Fluent in Spanish

EDUCATION & LICENSING

ASPE Business Analyst Boot Camp
Mesa, Arizona - 2015

Dale Carnegie Management Training
Coral Gables, Florida – 2013

Health, Life and Annuities License 2-15
Ft Lauderdale, Florida – 2005

High School Diploma
Miami, Florida – 1987