**Bhupinderpal Singh**

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**Summary:**

* Senior Business Analyst with over 8 Plus years of experience in delivering business and system solutions for leading providers of Health Care.
* Highly accomplished professional with a proven track record of leading complex, cross functional and result-oriented.
* Extensive experience gathering defining, business requirements (BRD) translating them into technical specifications and functional requirements (FRS) documents for the inbound and outbound EDI processes for HIPAA compliant files.
* Strong HIPAA EDI 4010 and 5010, analysis & compliance experience from payers, providers and exchanges perspective, with primary focus on Coordination of benefits.
* Worked with HIPAA/Electronic Data Interchange (EDI) transaction sets – 270/271,835,276/277 and 837 as well as Pharmacy Claims.
* Extensive experience in ETL process consisting of data transformation, sourcing, mapping, conversion and loading
* Competent in Creating Unified Modeling Language (UML) diagrams such as Use Case Diagrams, Activity Diagrams, Class Diagrams and Sequence Diagrams.
* Strong healthcare and Medicaid business configuration experience with focused primarily on claims adjudication, pricing, provider, member, enrollment, prior authorization.
* Very good exposure to MMIS systems.
* Proficient in all the phases of SDLC which includes analysis, design, development and deployment.
* Experienced in creating SQL queries and fine-tuning queries for testing Data Warehouse applications on databases like Oracle, Teradata, SQL Server and DB2.
* Involved in System Analysis, Design and Development of successful Business Solutions.
* Proficient in MS Office, MS Access, PowerPoint, MS Visio.
* Wrote SQL queries in Oracle databases (using TOAD).
* Served as a liaison between the business sponsor, vendors, and the IT infrastructure during analysis phase of the project.
* Developed object models using object oriented design methodologies and performed database modeling on conceptual and logical levels.
* Excellent work ethics, self-motivated, quick learner, team player and team oriented.

**Technical Skills:**

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| **Operating Systems:** | Mac OS X, Windows 2000/XP/NT, UNIX. |
| **Software development methodologies:** | RUP, SDLC, UML, SWOT, Six Sigma. |
| **Requirements Management Tools:** | Rational Requisite Pro. |
| **Business Modeling Tools:** | Rational Rose, MS Visio, WebSphere BusinessModeler (6.0.2.1) |
| **UML Diagrams:** | Rational Software Modeler |
| **Project Management Tools:** | MS Office, MS Project. |
| **Programming Languages:** | C, C++, Java, SQL, and PL/SQL. |
| **Data Bases:** | Microsoft Access, MS SQL Server 2000. |

**Professional Experience:**

**Emblem Health, NY (New York) May 2013 – Present**

**Sr. Business Analyst**

The Emblem Health story began 75 years ago with ideals rooted in a simple, yet pioneering vision: provide quality health insurance plans for working New Yorkers and their families.

Emblem Health companies—Group Health Incorporated (GHI) and the Health Insurance Plan of Greater New York (HIP)—did, and continue to do, just that.

**Section 1115 Waiver Special Terms and Conditions**

The New York State Department of Health proposed to CMS to integrate or provide care coordination for Medicare and Medicaid physical healthcare, behavioral healthcare and long term supports and services. This will be done through several coordinated approaches that involve both the managed fee for service and capitated models. As part of this approach, NYS required certain dual eligible age 21 and older, who require more than 120 days of community based long term supports and services to be enrolled into NYSDOH’sMLTCP (Managed Long Term Care Program) plans for receipt of their LTSS(Long-Term Service and Support)

In 2012 CMS approved the State proposal to require certain individuals using long term services and supports to enroll in MLTC programs. This is also referred to as Mandatory Enrollment.

The State is required to provide the following protections for this population;

* Person Centered Service Planning
* Health and Welfare of Enrollees
* Network of Qualified Providers

EH via the MLTCP program is required to comply with these directives, be able to demonstrate adherence to them, and provide the mandated reporting and documentation as defined by the State

**MLTC Care Management Partnership Implementation**

This project resulted from the State Department of Health (SDOH) 1115 Waiver Amendment which discusses the integration of Care for Dual Eligible Members. The Fee for Service option for Long Term Service and Support is being discontinued for all over 21 Dual Eligible individuals who require more than 120 days of community based long term support and services. As a result of this waiver amendment, Emblem Health (EH) will be positioned to increase its market share by; taking advantage of the large growth potential for Managed Long Term Care (MLTC) plans that are positioned to take advantage of the population of - over 21 Dual Eligible individuals and allowing EH to increase its membership base for over 21 Dual Eligible Membership by partnering with Personal Care Providers, while leveraging their existing relationship with their established members and their existing case management resource for seamless transition and growth.

**Fully Integrated Dual Advantage (FIDA) Demonstration**

The New York State Department of Health (NYSDOH) is implementing the Fully Integrated Dual Advantage (FIDA) program to integrate and provide care coordination for Medicare and Medicaid physical healthcare, behavioral healthcare, and long-term supports and services (LTSS) for a major segment of New York’s dual eligible population.  The program is built upon the framework established by the MLTC program.  The managed long term care (MLTC)system will continue to exist and will serve those who are not “dual eligible's" as well as dual eligible's that opt-out of FIDA , or at some point choose to disenroll from the FIDA program.

Through the FIDA program, full dual eligible would be provided with  benefits  such as, but not limited to:

* Seamless access to all physical health, behavioural health, and LTSS;
* A choice of plan and a choice of providers, with choices being facilitated by an independent, conflict-free Enrollment Broker;
* Care planning and care coordination by individualized interdisciplinary teams that are centered around each dual eligible;
* Consumer direction for personal care services;
* An independent, conflict-free, Participant Ombudsman to aid in any questions or problems the Participant has;
* Continuity of care provisions to ensure seamless transition into one’s FIDA plan;
* Articulated network adequacy and access standards; and
* New Health Education and Wellness benefit.

**Responsibilities:**

* Involved in the meeting with Business Process Owners, SME (Subject Matter Experts) and store users for Requirement gathering in Definition Stage.
* Established a business Analysis methodology around the SDLC, helped to develop use cases, project plans and manage scope.
* Maintained Traceability Matrix in Excel.
* Participated in user meetings, gathered Business requirements & specifications for the Data-warehouse design.
* Created Process Flow diagrams, Use case diagrams (UML) using MS-Visio
* Analyzed Business Requirements and segregated them into high level and low level Use Cases, Activity Diagrams/State Chart Diagrams (UML).
* Created workflow diagrams to better demonstrate the processes adopted in the EDI group and accounting groups of the company.
* Worked in SDLC using Rational Requisite Pro
* Extensively interacted with the stakeholders and the IT Department in finalizing the requirements according to the CMS Compliances/Regulations and HIPAA Regulations.
* Created new and modified existing reports using the Actuate Developer Workbench and integrated it with Siebel.
* Conducted the FRS reviews and walkthroughs with designers, developers and stakeholders.
* Prepared Screenshots and web layouts for the application
* Performed UAT based on Requirements Document

**ICD-10 - Vendor Management Work stream:**

The U.S. Department of Health and Human Services (HHS) announced the release of two final rules on January 16, 2009 that will facilitate the United States’ ongoing transition to an electronic health care environment through adoption of a new generation of diagnosis and procedure codes and updated standards for electronic health care and pharmacy transactions.

The first rule adopts two medical data code sets as Health Insurance Portability and Accountability Act of 1996 (HIPAA) standards for use in reporting diagnoses and inpatient hospital procedures in health care transactions (ICD-10 final rule).

The second final rule adopts an updated X12 standard, Version 5010 (5010) for certain electronic health care transactions, under the authority of HIPAA.

**ICD-10 Program Description:**

Due to the magnitude of remediating ICD codes throughout EH’s systems and policies and procedures, EH has formed a distinct program structure inclusive of a dedicated PMO to remediate I9 to ICD-10 codes. The program’s name is the ICD-10 (ICD-10) Remediation Program, and is organized into several Work stream.

**Vendor Management Work stream Description:**

Generally, EH’s existing vendor applications, third party interfaces, and related extracts and reports, do not support the ICD-10 final rule and need to be remediated. The Vendor Management Work stream, as part of the ICD-10 Remediation Program, will review, ascertain and document, as appropriate, the level of readiness of EH’s trading partners toward incorporating ICD-10 functionality in their own solutions, to minimize risk to EH’s own remediation efforts and timeline.

The primary context of this charter is based on the Work stream deliverables that includes:

* Vendors and applications master inventory.
* Monthly vendor readiness dashboards and vendor risk management reports.
* Vendor preliminary assessments and action plans.
* Collaboration with EH vendor Relationship Managers (RM) and Vendors.
* Identify, analyze, document and implement all changes necessary to ensure that the vendor transactions and the related business processes are successfully accepted, processed, loaded, generated, transmitted and converted to handle ICD-10 compliance readiness as outlined in the capable strategy adopted by EH.
* Create ability to capture both ICD-9 and ICD-10 data elements (with capability to distinguish ICD-9 codes from ICD-10) as it relates to vendor exchanges.

**Provider Network Management (PNM) Work stream Description:**

* Engage with the provider community to assess readiness.
* Vendor survey questionnaires, responses and related analysis.
* Develop contingency plans for providers who are not ready by the go-live date.
* Convert hospital contracts to an alternate inpatient methodology that is supported under ICD-10.
* Support financial neutrality in the conversion from ICD-9 to ICD-10.
* Vendor survey questionnaires, responses and related analysis.
* Ensure that all contracts and supporting documentation are ICD-10 compliant.

**Responsibilities:**

* Involved in preparing detailed Business Requirements document in accordance to SDLC deliverables.
* Conducted business requirement meetings with business unit teams to determine project goals and elicit requirements.
* Responsible for conducting Business Impact Analysis.
* Liaised with stakeholders, business owners, Collaboration with EH vendor Relationship Managers (RM) and Vendors and developed business/system use cases.
* Developed Business Requirements, User Requirements and upload into HP Quality Center 10.0.
* Managed Requirement Traceability Matrix (RTM) to trace and map Business requirements, Functional requirements and Technical requirements.
* Identify, analyze, document and implement all changes necessary to ensure that the vendor transactions and the related business processes are successfully accepted, processed, loaded, generated, transmitted and converted to handle ICD-10 compliance readiness as outlined in the capable strategy adopted by EH.
* Created Activity Diagrams & Sequence diagrams describing carrying out of actions in MS Visio.
* Performed Gap Analysis to assess the “AS IS “and “TO BE” scenarios.
* Tagged the requirements using SharePoint for both GAP analysis spreadsheet and requirements document.
* Documented the meeting minutes from the JAD's and stored the artifacts in the appropriate place holders in SharePoint for both the teams to review.
* Participated in testing strategy and document it in a test plan which contains purpose test types, schedule, scope, roles, entry and exit criteria, defect workflow, test deliverables, risks, assumptions, constraints & dependencies.
* Collaborated with business, and developers to finalize the scope of testing.
* Used Quality Center 10.0 for defect tracking and maintained the trailing history of the bugs.
* Extensively worked and published documents on SharePoint.
* Created and managed change requests alongside with updated scope and new changes.
* Worked with Benefit-focus staff to ensure requirements will be incorporated into system design and testing.
* Interacted with Development Team to fix the defects raised during the testing period.
* Prepared Traceability matrix, bug matrices, weekly and daily status reports and sent to management.
* Participated in weekly status report and defects review meetings.
* Performed/Participated in UAT testing of the application to test the system for both functional and business requirements.
* Identified frequency, dependency on time, triggers for each risk and escalate the risk on time.

**United health care, PA (Horsham) Sept 2012- April 2013**

**Sr. Business Analyst**

United Healthcare is an operating division of UnitedHealth Group, the largest single health carrier in the United States.

**Insurance Solutions Data Warehouse (ISDW)**

The purpose of this Project initiative is to create a smarter organization by establishing enterprise-wide data definitions, integrating the data, and developing interactive views to more quickly react to market opportunities, supporting smart growth. There will be more time spent on analysis and less time spent gathering and reconciling data. An integrated data source will be used by all divisions across our organization. The data will be extracted from the source systems and will be loaded into ISDW via staging environment. Staging environment will be used as a place holder for the data and the required transformation will be performed after extracting the data from the Staging environment and prior to loading it into the ISDW dimensional Data Mart. Once the data is available in the Data Mart, Mircrostrategy developers will produce necessary reports using different dimension and facts tables.

**Responsibilities:**

* Worked as the Lead Business System Analyst to improve Business Processes through investigation, analysis, review and documentation of all or part of a Data Life Cycle.
* Responsible for analyzing and identifying gaps between the target data and required client attributes.
* Worked with the ETL Informatica Team to Extract Claims (UCPS), enrollment (COMPAS) and marketing (SMART) from ADW, CDW, VSAM and DB2 and Transformed the Data and Load to ISDW data warehouse.
* Managed and Mentored the BA Team in achieving Project Deliverables and Deadlines on time.
* Created Transformation Rules Document for the COMPAS Data Mapping by conducting and facilitating requirement gathering sessions with the COMPASSMEs.
* Designed Use Cases using UML and managed the entire functional requirements life cycle.
* Done extensive Data Analysis and Validation of the Source to Target Data Mapping Using MS Excel.
* Helped in the Generation of Production Reports with the purpose of making conclusions from the Data for Business Decision Making Process.
* Supported the QA Team by organizing and facilitating Bug Triage Meetings to solve Data Quality issues.
* Created extensive BRD and FRD Documents, Test Case, Use Case and Mapping Rules Document.
* Used MS Excel, MS Access and SQL to analyze large sets of Data from Multiple Sources.
* Developed MS Power Point Presentations, Spreadsheets, Graphs and Analysis of project related information.
* Conducted Daily Meetings with the Onsite and Offshore Teams.

**Environment:** SQL Navigation 6.1, Microsoft SQL server 2008, Mainframe, Team track, DB2, MQ Series ,SQL Advantage, Java, J2EE, XML, UML, SOAP, Business Objects, Brio, MS-Word, Ms-Excel, Onyx, Unix, Tools.

**Health Plan Services (HPS), Tampa, FL Aug 11 –Aug 12**

**Sr. Business Analyst**

**Health Plan Services** is the largest independent provider of services for the insurance & managed care industries. They provide the most complete end-to-end sales, marketing and BPO solutions for the individual, voluntary and group market segments.

Health Plan Services (HPS) contracted to serve as a third party administrator (TPA) to support claims administration services for Freelancers Insurance Company (FIC) and Beazley Insurance Company which includes services and management for processing Claims, reporting, and interfaces established as a result of this implementation. There are were five health products being supported on HPS systems for Freelancer insurance company for which the claims were also paid this includes (3) three PPO plans and (2) two high deductible plans and for Beazley insurance company there were four (4) Group Voluntary products and two (2) Supplemental Medical products for which the claims were paid on beacon spyglass.

**Responsibilities:**

* Worked as a team member of a group of analysts in communicating with business and IT to analyze and document application system.
* Gathered, identified and documented business and test requirements.
* Updated the existing business requirement documents as a part of change management process to include and/or update new requirements.
* Based on the project change management documents gathered, analyzed and documented technical solutions for the BRDs.
* Worked closely with developers to understand and document technical logic for the medical claim adjudication systems.
* Documented the technical solutions of the business requirements as a part of Technical Requirement Document (TRD) for medical claim adjudication system.
* Tested and processed 837 Institutional, professional and dental claims on diamond which includes Adjustment, Pay Claim, Void Claim, Claim search, Pend Claim, Generate letters, checks and EOB’s.
* Worked on conversion claims, reporting, Baking and payment processing once the claims were processed.
* Experience in EDI testing process including validation of inbound and outbound X12 files, pharmacy claims, various loops and segments, claims in diamond
* Involved in testing method for data exchange for Outbound Eligibility 834 File, Pre-Certification Transmitted from HPS to AMM and File and Medical Case Management Transmitted from AMM to HPS.
* Worked on Validated Eligibility load from TAS to spyglass once the cases were issued on CSR.
* Created claims, members, groups using Diamond
* Involved in developing Test Plan and created Test Cases as per the business requirements in Quality center for Patient Registration Module
* Extensively involved in creating test data and executing the test cases for the UNIX batch jobs.
* Worked on Validated fill file (enrollment data).
* Worked on Validated member and their attributed on CSR.
* Work on validating Broker Portal which included validating Quote Generation, Quote Output, Broker Links and Access and Discount Buckets per Producer roles as defined in requirements
* Analyzed BRDs, SRSs to ensure 100% Requirements coverage in execution of Test cases.
* Validated 837 (Institutional, Professional) 835, and 834 HIPAA Transaction sets and X12 messages
* Discuss enhancements and modifications with the Project Team
* Use team track to track, analyze, and log the defects to report them to developers.
* Compared the parser generated XML claim data with slicer generated CU files to validate the claim match.
* Reported the project status and activities to the Supervisor on weekly basis.
* Involved in preparing the Test cases, Test data in Team track for Report Repository upgrade.
* Work with the Developers, Infrastructure teams to resolve the issues.
* Have written and executed SQL queries to ensure that member plan attributes and CIM numbers are associated with members under specific carrier appropriately and no Duplicate or Improper allocation of member attributes and CIM numbers are done.
* Extensively used Agile Methodology and Adhoc testing for the applications.
* Tracked and managed problems during UAT.

**Med3000, Pensacola, FL July 10- Aug 11**

**Business Analyst**

The project objective is to Upgrade the Facets System from version 4.41 to 4.71. The organization needs to be on a current version of Facets to allow testing of the HIPAA 5010 Project. An additional driver of the project is to be on a current version of Facets for the ITS 11.2 upgrade.

**Responsibilities:**

* Involved in Business System Analysis for Inbound and Outbound Transactions.
* Provided day-to-day EDI translator support.
* Created S.R.S (system required specifications) document and analysis document explaining all the aspect of 5010 834.
* Performed gap analysis between partner specs and internal system requirements by matching HIPAA 4010 to 5010 implementation techniques.
* Built a business   process model using MS Visio.
* Analyzed BRDs, SRSs to ensure 100% Requirements coverage in execution of Test cases.
* Worked on 270,271 Eligibility request and Eligibility response and on 276,277 Claim status request and response.
* Validated that the 270/271 generated is in accordance with the 5010 implementation guide.
* Prepared Test cases for 27X transactions according to the requirements.
* Used FACETS 4.71: Subscriber/Member, Medical Plan to validate the Eligibility benefits received in the 271 response.
* Constantly involved in review meetings and made sure testing is done based on the QA master plan and deadlines are met.
* Used FACETS to provide seamless transactions between the provider, members and the plan.
* Used SQL Queries to verify the data from the Sybase database.
* Used spec builder to validate 837 professional & dental EDI.
* Request and Response are generated according to the 5010 format. Validated the same.
* Creating and consolidating SIT Test Cases and UAT test Cases using MS Excel.
* Preparing sample Test Data and executing Test cases using rational quality manager.
* Provide support to end users while execution of UAT with proper test scenarios & test data.
* Monitor rational quality manager to close the defects/cases as and when developers resolved the defects
* Communicated with developers and Business Analysts through all phases of testing to prioritize defect resolution.
* Reporting the Test Execution status to the project manager on daily basis.
* Logging & re-testing defects and assigning them to the developers/responsible persons
* Good understanding of 5010 conversion initiative
* Actively involved in weekly walkthrough meetings and Daily Defect calls to verify the status of the testing efforts meeting the deadlines & mid-term targets.

**Cardinal Health, Dublin, OH            Jan 08 - Jun 10**

**Business Analyst**

Cardinal Health provides customers with expertise, benefits, and services that seek to improve their well-being. My role as a Business Analyst comprised developing fully automated, real-time claims processing system for complete, on-line mediation of medical, dental, vision, and disability claims following HIPAA guidelines. The system allowed the efficient and timely management of all relevant data- clinical, financial, and administrative throughout the organization enabling the sharing of information between subsystems.

**Responsibilities:**

* Utilized and improved my understanding of HIPAA transaction codes specifically on 834 to incorporate EDI X12 - 4010enhancements to existing efforts on capturing and mapping, member enrollment and eligibility and contribution data respectively received at the Plan level from the State.
* Provided expertise in strategic planning, business process modeling, business process analysis, object-oriented analysis & design, use case modeling, use case analysis, component-based development, and quality assurance.
* Documented the meeting minutes from the JAD's and stored the artifacts in the appropriate place holders in PDS and SharePoint for both the teams to review.
* Worked in GAP analysis to understand the difference between both the billing systems and documented the GAPs in GAP analysis spreadsheet.
* Used UML and RUP best practice methodologies along with supporting toolset including Mercury Test Director, Caliber RM and StarTeam for overall development framework
* Documented the business requirements into high-level requirements document.
* Gathered the requirements and transformed them into high-level Process-Flow Diagram using PowerPoint.
* Tagged the requirements using PDS and SharePoint for both GAP analysis spreadsheet and requirements document.
* Created a task plan for the team identifying the key deliverables and the respective deadlines.
* Supported users with word processing, spreadsheets, databases and presentation software. Created and developed the TO-BE system presentations using PowerPoint.
* Analyzed the business requirement as per the HIPAA rules and regulations.
* Adhered data transition of the payment and remittance advice as per the EDI standard 835.
* Involved in preparing Test Plans based on User Requirements Document (URD) and prepared the Test Cases using Test Director/HP Quality Center.
* Created mapping/crosswalk documents for mapping data flow between systems.
* Generated SoDa report from the Sequence diagrams to show the sequence of interactions between the actor, boundary and the system using Rational Rose and created Use Case Realization.

**Well care Health Plans, Tampa, FL Feb 06 – Dec 07**

**Business System Analyst**

Wellcare Health Plans Inc is the premier provider in the United States of high quality, personalized public sector health care programs, serving more than three million people in Medicaid, Medicare and Children's Health Insurance Programs. The first project I worked was Georgia Family Planning – Premium Reconciliation. Premium reconciliation is a process that pulls the enrollment information and the remit information into the data warehouse and reconciles the three pieces of information (remit data, enrollment data, and rates). The Remittance advice comes through the 820. The 820 has the member name, Medicaid number, coverage month, and remit amount. It also has identification that tells us which state sent us the file. The second project was Magellan 837I, 837P and 835 reconciliation. Business would like views to be created for claims from the data warehouse. This allows for better organizational control and workflow improvement. The tickets I worked on are from SAS and Cognos Reporting.

**Responsibilities:**

* As a business analyst, interviewed several business users to determine analytical and reporting needs and converted them into report prototypes and data requirements.
* Customized the data quality guidelines to support Wellcare’s Health Intelligence initiative (a data warehouse built to consolidate data from various health plans)
* Interfaced with development team and helped design reports in a Cognos environment
* Part of a business consulting team, developed a master-plan and strategy roadmap for a new enterprise data warehouse for regional healthcare payer in MO and HI.
* Analyzed various subject areas and prioritized their phasing into warehouse based on cost-benefit analysis.
* Warehouse Developing and implementing an Analytics and Business Intelligence line of business for several different clients.
* Designing and architecting end-to-end ETL process including data Extraction, Transformation and Loading from source systems using Informatica.
* Designing and creating the architecture of data warehousing star schema logical database model using Erwin.
* Design, Gather Requirements, develop and implement client specific database marketing data warehouses using SQL Server Management Studio.
* Analytical reports using SQL Server 2005, 2008 Business Intelligence Development Studio.
* Develop and implement an easy client internet access portal for viewing and downloading reports.
* Gather Information to map and convert data types to new data stores from old or out-dated systems.
* Provide clear specifications to the software teams. Define functional and quality.