Non-Union Exempt Position Summary

		JOB CODE:	10
POSITION TITLE:	Operational Compliance Analyst	**DATE:**	January 2022
DIVISIONS:	Compliance		
REPORTS DIRECTLY TO:	Compliance Officer		

POSITION PURPOSE

The Fulcrum Health, Inc. (Fulcrum) Operational Compliance Analyst will assist and support the compliance department in ensuring the organization has an effective compliance program. They will support the Chief Compliance Officer in development of department policy, processes, procedures, training programs and the day-to-day operations of the Compliance department, in addition to supporting core delegated business operation functions in this shared role working with the Chief Operations Officer. Responsibilities will include conducting routine audits designed to test and confirm compliance with applicable state and federal laws and regulations, contractual agreements, NCQA accreditation(s), as well as internal policies and procedures. Additionally, the Operational Compliance Analyst will assist in the investigation and research of compliance issues, such as allegations of HIPAA violations, fraud/waste/abuse, and other compliance issues.

This position is a hybrid role between traditional compliance functions and responsibilities attributed to the handling of complaints, appeals and grievances (CAG). This position will also be responsible for operational and administrative tasks related to the intake of CAG's for Fulcrum clients (up-stream health plans). Responsibilities include coordinating the identification, documentation, appeals, and grievances appropriately and timely according to contractual timelines.

ACCOUNTABILITIES:

- **Conduct Ongoing Monitoring and General Compliance Support**
  - Support provider investigations, monitoring activities and other fraud, waste, and abuse initiatives through data analysis, coordination of written provider outreach, file reviews, etc.
  - Establish positive working relationships with Fulcrum stakeholders to provide input on risks and controls, and ensure a sustained understanding of compliance requirements while maintaining independence and objectivity
- **Complaints, Appeals and Grievances**

- Analyze, answer, resolve, and document incoming telephone calls from members, providers, internal departments, and external customers and regulators
- Consistently monitor and research incoming appeals and grievances requests and inquiries; including potential expedites, from mail, voicemail, fax, and email
- Contact members, providers, health plan customers, and delegates as necessary to proactively obtain information required to complete appeals and grievances and educate on the process
- Ensure all appeals and grievances are entered in the system and maintain accurate documentation according to State, Federal or Commercial regulatory guidelines.
- Manage a caseload of appeals and grievances along with managing all other intake duties as stated above

- **Participate in External Audits, e.g. Health Plan Customers, CMS, DHS, NCQA, etc.**
  - Conduct initial file review for compliance with customer instructions and audit elements, i.e. NCQA, state and federal requirements
  - Help coordinate implementation and monitoring of activity, including any necessary corrective action plans, to reduce exposure and correct defective policies
- **Business Operations**
  - Support Credentialing and Network Management business operations teams; performing assigned tasks for completion of the network provider credentialing and recredentialing processes
  - Serve as a backup for maintenance operational data management and reporting processes to ensure adherence to regulatory, accreditation and contractual requirements
- Other projects or duties as assigned.

REQUIRED QUALIFICATIONS: (*Minimum qualifications needed for this position)*

- Associates Degree or 5 years of related work experience in lieu of a degree
- 4 or more years of experience in a health care Compliance, Audit, or CAG department within a health care organization
- Well-developed organizational skills with the ability to prioritize multiple time-sensitive assignments
- Understanding of business processes and audit functions
- Strong skills using Microsoft Office (primarily Word, Excel, Power Point and Outlook) and a willingness to learn other software applications
- Ability to work independently and contribute to a positive team atmosphere

PREFERRED QUALIFICATIONS:

- 4 or more years of experience addressing member complaints, internal concerns, and/or incident reports
- Experience answering benefit and claim questions. Claims adjudication process experience.

DIRECT/INDIRECT REPORTS:
Number of direct reports and titles: 0
Number of indirect reports: 0