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Before the
U.S. Senate Homeland Security and Government Affairs Committee's Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security

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Chairman Carper, Ranking Member McCain, and Members of the Subcommittee, thank you for the opportunity to testify today on the challenges and opportunities of Medicare Drug Integrity Contractors (MEDICs) in identifying Medicare Part D fraud and abuse.

I serve as the Chief Executive Officer of Quality Health Strategies and as a Member of the Board of Directors of Health Integrity, LLC, one of our subsidiaries. I have 20 years of experience as Medical Director for a number of corporations, including Delmarva Foundation, The DuPont Co., and Computer Sciences Corporation (CSC). In my tenure with CSC, I served as the Medical Director for the Western Integrity Center, a Program Safeguard Contract of the Centers for Medicare & Medicaid Services (CMS). I am a retired Captain in the U.S. Naval Reserve and have served as Commanding Officer of four Naval Medical Reserve units.

Health Integrity was awarded the first Enrollment and Eligibility MEDIC by CMS in September 2005. Our task during this period was to identify potential fraud during the initial enrollment phase and first year of the Part D Program. The following year, two additional MEDIC contractors assumed regional responsibility for Part D complaints and investigations, while Health Integrity assumed Part D benefit integrity responsibility for the Southeastern United States. In September 2008, Health Integrity assumed responsibility for seven additional states and became the South MEDIC covering West Virginia, Virginia, North Carolina, South Carolina, Tennessee, Georgia, Florida, Alabama, Mississippi, Arizona, Louisiana, Oklahoma, Texas, Colorado, New Mexico, and Puerto Rico.

In November 2009, as a result of a positive restructuring of the program by CMS, Health Integrity became the National Benefit Integrity (NBI) MEDIC. Compliance and enforcement issues are now handled by another MEDIC contractor, SafeGuard Services (SGS). As the NBI MEDIC, Health Integrity has responsibility for fraud, waste, and abuse issues in all parts of the United States, and is the contractor responsible for performing benefit integrity tasks for CMS related to the Medicare Part D Prescription Drug Program. In addition to monitoring complaints received through our national call center and initiating fraud investigations for referral to the Office of Inspector General (OIG), Health Integrity performs proactive data analysis to identify new and emerging fraud patterns, applies medical and pharmaceutical experience, performs audits, and provides training.

In September 2008, Health Integrity was awarded the first Zone Program Integrity Contract (ZPIC Zone 4) covering Texas, Colorado, Oklahoma, and New Mexico. We were awarded

the Umbrella Indefinite Quantity Contract and two Task Orders under the Indefinite Delivery/Indefinite Quantity (IDIQ) Contract. Task Order 1 is to perform Fee for Service (FFS) fraud and abuse detection and investigation for Part A, B, Durable Medical Equipment (DME), Home Health, and Hospice. Task Order 2 is to perform Medi-Medi fraud and abuse detection and investigation. In September 2009, we were also awarded Task Order 3 to perform Home Health fraud detection and investigation in Texas.

In September 2009, CMS also awarded Health Integrity two Audit Medicaid Integrity Contract (Audit MIC) Task Orders: Task Order 5, which performs fraud, waste, and abuse audits for Medicaid providers for 10 Midwestern states: Minnesota, Wisconsin, Michigan, Nebraska, Iowa, Illinois, Indiana, Ohio, Kansas, and Missouri; and the Task Order for the Southeast region of the U.S. (ranging from Pennsylvania to Florida). In combination with our MIC 5 award, Health Integrity has 23 states and the District of Columbia in which we perform four types of fraud, waste, and abuse audits of Medicaid providers: comprehensive onsite audits, focused onsite audits, desk audits, and cost report audits.

CMS has undertaken some bold, but necessary, steps to integrate, streamline, and improve Medicare and Medicaid program integrity. Implementing program integrity strategies for the new Medicare Prescription Drug Program had unique differences not found in the Medicare Fee For Service or Medicare Managed Care Programs. For example, the Prescription Drug Event (PDE) data is less mature, the Risk Share Model more complex, and regulations restrict MEDICs direct access to records of down-stream entities such as pharmacies and providers.

Because of these differences in the Medicare Prescription Drug Program, CMS and the MEDICs needed to perform educational activities for Plan Sponsors and external partners such as law enforcement to assure a better understanding of the Program's unique characteristics. As with any new program, improvement opportunities develop as the program evolves. CMS should be praised for responding to those opportunities as they occurred.

The OIG's October 2009 report focused on what the MEDIC program encountered prior to and during 2008. Many challenges were overcome in 2009, and it is pleasure to report the accomplishments Health Integrity has made during the past year. The chart below highlights these accomplishments and captures Health Integrity's workload activity in 2009.

Health Integrity 2009 Workload Accomplishments	
Call Center Complaints Received and Processed	2,488
Requests Processed for Essential Case Data to Law Enforcement	138
Fraud Case Referrals to Law Enforcement	121
Referrals of Insurance Agent/Brokers to State Insurance Commissioners	157
Investigations as a Result of Proactive Measures	267

Specific accomplishments from 2009 include:

1. Health Integrity gained experience working with the data to perform more proactive data mining and analyses. Doing so has resulted in a substantial increase in the percentage of total investigations generated by proactive analyses as compared to investigations originating from external sources. During 2009, Health Integrity performed 47 proactive analyses, and these led to 267 investigations. Twenty eight percent of their total investigations resulted from proactive analyses. This is an improvement from the OIG Report where 4 percent was reported for all MEDICs in 2008. A total of 12 referrals resulting from proactive analyses have been made since January, 2009. However, 203 proactive investigations are being actively pursued. External cases received from Plan Sponsors have also dramatically increased from 89 in 2007 to 640 since January of 2009. Additionally, Health Integrity received access to Part B Data in 2009 and this has substantially increased our cross claims proactive data analysis capability and proactive investigation workload.

2. Health Integrity focused its outreach efforts in 2008 and 2009 to ensure federal law enforcement was fully trained in all the program issues that affect Part D investigations and potential prosecutions. For instance, Health Integrity helped lead the efforts to determine the financial impact of fraud on the government for Medicare Part D cases, a critical component for prosecution of health care cases. As a result, we have seen three Part D indictments in 2009 and 2010.

3. Health Integrity has had substantial success in collaborating on fraud, waste, and abuse investigation with Plan Sponsors. We established Part D and Part C Plan Working Groups which meet on a quarterly basis to share information and collaborate with law enforcement, Plan Sponsors, and ZPICs on fraud case development. These working groups have increased plans' awareness of MEDIC operations and improved Plan Sponsor referrals of potential fraud. Health Integrity received 89 referrals in 2007, 277 referrals in 2008, and 396 referrals in 2009. In the first 2 months of 2010 Health Integrity received 244 referrals as the NBI MEDIC.

4. Health Integrity performed 10 Compliance Plan Audits this past year and worked closely with CMS on several Compliance Initiatives. CMS recognizes the value of Compliance Plan activities and has dedicated a substantial amount of resources to the compliance oversight of Part D Plans through creating the Compliance and Enforcement MEDIC to decrease these vulnerabilities.

With such a complex program there will always be challenges but we expect even greater opportunities and outcomes in 2010. Indeed, although Health Integrity has only been the National Benefit Integrity MEDIC since October 2009, already this national perspective has strengthened our ability to:

- Identify new and emerging regional fraud schemes and patterns affecting Part D before they develop into national scope issues.

- Identify existing national scope issues.
- Focus our effectiveness at preventing potential fraud schemes from developing through vulnerability reporting, fraud alerts, and other measures.

I would like to thank the Subcommittee for this opportunity to offer my comments. This concludes my prepared statement, and I would be pleased to answer any questions the Subcommittee may have.