Curriculum Vitae

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SUMMARY

Alex Oliphant is an associate director in BRG's Health Analytics practice in Washington, DC. He has provided analytical and strategic insight for litigation and management consulting matters for more than ten years. He has wide-ranging experience managing teams tasked with designing custom algorithms to analyze medical and pharmaceutical claims for engagements involving commercial health insurers, pharmaceutical manufacturers, federal health agencies, state regulatory entities, hospital systems, and state worker-compensation agencies. His work involves assessing the accuracy of reimbursement of medical and pharmaceutical claims, conducting financial analysis on the impact of potential inaccurate claims submissions, designing statistically valid sampling methodologies for auditing claim submissions, and developing customizable front-end applications for streamlining the claim audit process.

Mr. Oliphant has extensive experience with risk adjustment in the context of Medicare Advantage–related engagements and strong understanding of the mechanics of the CMS-HCC model. He has applied his understanding of CMS MRA data, claims data, and membership data when leading teams that have analyzed large datasets to investigate provider diagnosing behavior. He has also designed statistically valid sampling methodologies for conducting medical record reviews and has developed sophisticated front-end applications that record, run quality checks on, and summarize medical record review results.

Mr. Oliphant has served as the technical lead on engagements involving 340B compliance monitoring for large pharmaceutical manufacturers. He has constructed models based on pharmaceutical pricing and utilization datasets, Office of Pharmacy Affairs–related datasets, hospital cost report data, CMS claims data, and state Medicaid claims data to identify entities that may be diverting 340B product or creating duplicate discounts.

PROFESSIONAL EXPERIENCE

Fraud / Regulatory Compliance Investigations

- Managed a team of coders, clinicians, and data analysts with investigating specific providers identified in a qui tam complaint for a Fortune 500 health insurer. Designed and executed a sampling methodology for conducting a chart review of MRA related encounters to determine validity of the submissions. Developed a dynamic front end application to record, analyze, and perform quality control on the audit results. Provided technical support for a team that analyzed

CMS MRA data, internal claims data, and enrollment data to benchmark centers of interest against a population.

- Managed team assigned with analyzing a large claims dataset consisting of roughly 70 million claims to support an internal fraud investigation for a Fortune 500 health insurer. Developed and applied an algorithm to the claims dataset to identify potential fraudulent claims and encounters related to a Medical Services Organization. Results were used to identify member's claims and encounters for a chart audit review. Identified and resolved data errors found in client's chart audit results reporting and collaborated with client's MRA audit team to implement new testing procedures and protocol related to chart audit results reporting.

- Lead analyst for an internal investigation matter for a Fortune 500 commercial health insurer tasked with identifying impact of programmatic errors resulting in corrupted encounter data. Analyzed over 100 million records of medical encounter data and determined validity of data by using uncompromised data sets to check against corrupted data. Executed CMS-HCC risk adjustment model to estimate impact of programmatic error and identified roughly $150 million in overpayments by the Centers for Medicare and Medicaid Services.

Litigation Support

- Analyzed dataset of 3.4 million health system claims and financial data related to a contract dispute between a hospital system and a managed care organization regarding a risk sharing agreement for the State of Texas Access Reform (STAR) Medicaid Managed Care program. Performed statistical analysis by financial class. Combined payment methodologies from produced contracts and fee schedules; deposition testimony; publicly available Medicaid fee schedules; and usual, customary, and reasonable rates in order to re-price claims to determine if claims were properly paid. The two parties reached a favorable settlement agreement.

- Managed project team tasked with developing fact patterns and financial analysis to evaluate allegations in a qui tam lawsuit between a former employee and a large diabetic pharmaceutical and medical equipment supplier. Developed project plan, reconstructed financial process, and analyzed financial data used in inputs, intermediate steps, and outputs. Fact pattern and financial analysis was presented along with legal analysis to Department of Justice.

- Supported expert analysis and testimony in a contract dispute between a health care data provider and a health care data aggregator. Compared differences in dataset delivered to client and data set sold to third party at a lower price to help support determination if the sale constituted a violation of the most favored nations clause of contract between the two parties. Contributed to writing the expert report submitted in the arbitration.

Strategic Consulting

- Lead technical expert for development of a dynamic analysis tool for large pharmaceutical manufacturers used to identify entities potentially diverting pharmaceutical products purchased at 340B prices to non-340B-eligible patients or creating duplicate discounts. Supervised collection, management, and analysis of client and public datasets. Applied knowledge of statistical theory to identify outlier entities. Developed front end dynamic reporting tool.

- Managed a team tasked with developing a MRA related chart review application for a Fortune 500 health insurer. Designed and constructed back end database architecture to store and manage chart review related data. Programmed statistical functionality to automate sample selection process. Developed dynamic front end navigation and reporting application.

- Managed a team of data analysts tasked with calculating potential overpayments from a state Medicaid program to a hospital system due to a technical error resulting in improper reporting of actual acquisition cost for pharmaceutical products purchased under the 340B program. Supervised client data collection, loading, and management. Designed programs to calculate potential overpayments. The results of the analysis were used in a disclosure made to the regulatory agency.

- Managed a team that developed a sophisticated and dynamic front end application used to calculate the Medicaid rebate liability for a mid-sized Pharmaceutical manufacturer. Calculated estimated impact of Medicaid expansion on rebate liability and 340B related utilization. Assisted with designing back end table structure and executed the table creation. Managed consolidation of client data, creation of front end forms, and reporting functionality. Programmed all dynamic functionality in VBA.

EDUCATION

B.A University of Virginia, 2004

PRESENT POSITION

Associate Director, Berkeley Research Group, 2010 – present

PREVIOUS POSITIONS

Senior Associate, LECG, 2005 – 2010
Systems Analyst, Primus Telecommunications, 2004 – 2005