Curriculum Vitae

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SUMMARY

Julie Nielsen is a managing director in BRG's Health Analytics practice, where she specializes in providing dispute resolution, litigation support, forensic investigation, and data analysis services to healthcare entities and their legal counsel. She has over thirty years of consulting experience spanning a variety of payers, providers, and manufacturers, including hospitals, physicians, clinical laboratories, pharmacies, managed care organizations, health plans, third-party administrators, pharmacy benefit managers, and pharmaceutical and medical device manufacturers. Ms. Nielsen primarily advises clients and their counsel with addressing liability, economic damages, and class certification issues related to investigations, litigation, and disputes, including:

- Conducting and assisting with internal investigations as a privileged consultant
- Analyzing and assisting with responding to fraud or other allegations made during government investigations
- Assessing economic impact of alleged noncompliance with contractual obligations and federal, state, and local regulations
- Providing damages and industry-specific litigation and dispute resolution support, including complex data analytics and financial modeling
- Performing compliance and fraud risk assessments and developing risk management programs
- Assessing current and historic billing, claims processing, and claims reporting operations

Ms. Nielsen focuses much of her work on assessing internal controls and regulatory compliance risks under Medicare, Medicaid, and commercial contracts; and assisting clients facing allegations of violations of the False Claims Act, Anti-Kickback Statute, or other legal, regulatory, or contractual requirements. She has detailed knowledge of the billing, payment, financial, and other transactional data systems maintained by various parties in the healthcare system. She specializes in marrying key transactional data, such as healthcare claims and member eligibility data, with her expertise in billing, coding, claims processing, and reimbursement. This enables her to provide clients with a more global view of the issues or allegations and enhances her ability to develop timely, independent, and supportable conclusions and opinions.

Over the past fifteen years, Ms. Nielsen has focused much of her work on assisting Medicare Advantage organizations (MAOs) with addressing government enforcement and regulatory compliance issues in the

risk adjustment area. In particular, she has assisted MAOs, large physician groups and management services organizations, and private equity firms with:

- Performing operational and compliance risk assessments of Medicare Risk Adjustment (MRA) policies, programs, and practices, including coding policies and practices, retrospective chart reviews, health risk assessments, and prospective programs
- Working with counsel and MAOs to develop and implement compliance activities aimed at minimizing compliance and enforcement risks, particularly around MRA programs and diagnosis code capture
- Performing complex risk adjustment-focused data analytics using historical claims, encounter, and prescription drug data to identify other provider submissions or clinical indicators supporting the diagnosis codes submitted to the Centers for Medicare and Medicaid Services (CMS)
- Performing analyses of diagnosis code submissions by network providers to identify potential outliers for certain providers or conditions that may require further investigation
- Leading investigations into billing and coding practices by providers and third-party vendors, including extensive medical chart reviews to evaluate the documented support for diagnoses submitted to CMS and assisting MAOs with self-disclosures and submission of deletions of unsupported diagnosis codes
- Providing privileged consulting expertise and assistance to counsel for MAOs being investigated by the Department of Justice (DOJ) for potential false claims
- Assisting MAOs with responding to CMS and Office of Inspector General (OIG) risk adjustment data validation audits

PROFESSIONAL EXPERIENCE

Government and Internal Investigations

Health Plan Investigations – Medicare Advantage

- Led or co-led several teams that have worked with outside counsel to assist multiple MAOs with conducting internal investigations and responding to government investigations into the accuracy of diagnosis codes reported by contracted providers and ultimately submitted to the government by the health plan under the MRA program. These engagements have generally involved designing sampling plans for the review of medical records, leading the review of medical records by certified coders and clinicians to assess the level of documented support for diagnosis codes reported, analyzing historical claims and encounter data to identify other documentation or clinical indicators potentially supporting the diagnosis codes, and assisting counsel and the health plan with results reporting, financial impact analysis and remediation efforts, including preparing deletion files of unsupported diagnosis codes for submission to CMS.

Health Plan Investigation – Medicare Advantage and Medicaid

- Co-managed a team that worked with outside counsel to conduct a multi-faceted internal investigation of a health plan that offered Medicare Advantage and Medicaid managed care plans to eligible populations. The investigation included reviews/analysis of:

    - Relationships between health plan Medicaid outreach employees, health plan employed/contracted sales agents, contracted primary care physicians, and interested non-profit entities
    - Advances and loans made to contracted physician groups and primary care physicians
    - Policies and procedures for receiving and processing contestations regarding capitation payments made to contracted physicians
    - Policies and practices for reviewing medical records for properly documented diagnosis code information and the reporting of those diagnosis codes to CMS for MRA purposes
    - Employee expense reports for compliance with company policies and federal and state regulations
    - Accounts payable entries for compliance with company policies and federal and state regulations

Hospital Billing Investigation

- Led a team in reviewing the billing practices of a clinician providing child advocacy services to publicly insured children. Review consisted of performing utilization review and frequency analyses of the clinician's billing records over a period of 21 months to identify trends and outliers in the billing data of the clinician. Engagement tasks included:
    - Developing a sampling methodology and selecting a statistically valid random sample of billing transactions covering the 21-month period
    - Leading the team in performing detailed reviews of these transactions and supporting documentation to determine the legitimacy of the billing
    - Quantifying potential exposure of the client to the public payer for all billing transactions that could not be supported through billing documentation
    - Presenting the findings to the client advisory committee leading the investigation

Criminal Investigation of Hospital Executives

- Co-managed work on a criminal matter involving the tracing and reconstruction of the events surrounding an alleged fraudulent borrowing from restricted hospital endowment funds. Engagement involved the tracing, reconstruction and reconciliation of over 700 endowment accounts through collection and analysis of corporate and trust documents and reviews of the hospital system's cash operating account. Engagement responsibilities included:
    - Leading a team of five to eight consultants in locating key endowment and financial documents maintained by the bankruptcy trustee, the State, and the surviving organizations
    - Creating and maintaining a database to log and quantify all of the information by endowment fund
    - Organizing paper trails of information to assist the Attorney General in his prosecution
    - Preparing an expert report

Mail Order Pharmacy Fraud Investigation

- Managed an internal investigation of Medicare and Medicaid billing practices for a large mail order pharmacy. Led the team in performing detailed reviews of a sample of Medicare and Medicaid patient files to identify potential overpayment and duplicate payment situations. Reviews consisted of verifying the patient's coverage information, determining whether coordination of benefits between payers existed, identifying claims that were either billed to the wrong payer or billed to multiple payers, quantifying the potential overpayments resulting from the erroneous billings, and determining whether refunds were properly issued upon request. Based on the findings, developed an economic exposure model and met with counsel from the U.S Attorney's office to present model and advise on negotiating a settlement.

Pharmacy Billing Investigation

- Managed a team of six consultants in reviewing pharmacy transactions for proper accounting of refusal and return transactions. The engagement included a focused audit on all identifiable refusal and return transactions occurring at one of seven client pharmacies over an 11-month period. At audit completion, the dollar impact at that pharmacy was quantified and the results were extrapolated across all seven pharmacies over a 21-month period. The extrapolation took many factors into account at each pharmacy over the period, including varying sales volumes, accounting methodologies, and changes in policies and personnel. The results of the audit and extrapolation were utilized by the client and its counsel in negotiating a fair and reasonable settlement with the State Medicaid agency investigating the matter.

Medicare Fraud Investigations

- Assisted on several investigations into allegations of fraudulent reporting to the Centers for Medicare and Medicaid Services (CMS) by Medicare Administrative Contractors. Engagements included the selection and audit of statistically valid samples of claims that had been adjudicated by the payers. Engagement tasks included:
    - Identifying relevant populations of claims to be tested and generating statistically valid random samples from these populations
    - Testing claims processing timeliness and accuracy
    - Quantifying errors identified in claims tested
    - Developing extrapolation methodologies to calculate total under- or overpayments within each population of claims

Litigation and Dispute Matters

Management Services Organization Risk Pool Dispute with Medicare Advantage Organization

- Co-led an engagement team providing managed care industry, Medicare Advantage and Medicare Part D expertise to a physician management services organization in a dispute with a Medicare Advantage plan over the settlement of annual risk pools. Key engagement tasks included recalculating premium revenues and assessing claims, pharmaceutical and other expenditures assessed against the risk pool. Two BRG experts have provided expert reports and deposition testimony.

Hospital Disputes with IT Vendor

- Led two engagements for IT vendors that were responsible for staffing and operating the business office and revenue cycle operations for two hospitals. The hospitals alleged that the vendors underperformed and sought damages for lost collections. Engagement tasks included:
    - Analyzing the billing and collections during the period that the vendors operated the business office to identify trends, including the source of any billing and collections issues and the responsible party
    - Assessing the hospitals' damages claim and analyzing financial data such as bad debt expense, contractual allowances, net revenues, reimbursement rates, utilization and case mix index to identify reasons for a drop in collection rates
    - Supporting BRG testifying experts with written reports and testimony preparation and rebutting reports and testimony of hospitals' experts

Hospital Class Action Litigation

- Led engagement teams working with counsel for defendant hospitals on more than 20 class action cases in which each class alleged the hospitals overbilled patients (both insured and uninsured) for services rendered. In the uninsured cases, the proposed class members alleged that the hospital's charges were excessive and uninsured patients should not be liable for paying the hospital more than health insurers typically pay. In the insured cases, the proposed class members alleged that for services rendered as the result of injury by a tortfeasor (e.g., auto accident, worker's compensation), the hospital should not have been reimbursed in excess of the amount the patient's health insurer had contracted with the hospital to pay, even though the health insurer was not the primary liable party. Ms. Nielsen's teams have advised counsel with the following on each of these cases:
    - Formulating analysis on class certification, including using patient-specific data to differentiate experiences of each potential class member and developing decision trees illustrating the differences
    - Providing industry information on hospital charge structures and the impact on that structure of unpaid bills by uninsured patients and other parties
    - Demonstrating that the charges of the defendant hospital were reasonable based on industry-standard definitions of reasonableness
    - Testifying to industry history and contracting standards

Health Plan 'Usual, Customary and Reasonable' Class Certification Analysis

- Co-led an engagement team working with a BRG expert and counsel for a health plan facing allegations by a class of patients and non-MD providers of using a "flawed" Ingenix database to price claims from non-contracted/out-of-network providers at usual, customary and reasonable rates (UCR), thereby resulting in reimbursement at amounts lower than UCR. Engagement tasks included:
    - Analyzing the out-of-network claims submitted during the defined class period by the named Plaintiffs to demonstrate that:
        - the named Plaintiffs were not adequate class representatives due to conflicting interests between the named Plaintiffs and the potential class members, as well as between the named Plaintiffs themselves

        - the claims of the named Plaintiffs were not typical of the claims of other potential class members
        - individual issues predominated over common issues and to accurately assess potential damages, a claim-by-claim analysis would have to be performed, thereby rendering the class unmanageable
    - Providing industry information on the history of health insurance and development of premium and reimbursement rates, including UCR
    - Developing a class certification expert report and rebuttal report

Payer/Provider Disputes

- Led a variety of engagement teams working with legal counsel for hospitals or health insurers involved in disputes over reimbursement rates for both contracted and non-contracted services. The primary areas of dispute in these cases have involved:
    - Analysis and application of contractual clauses, such as clauses regarding reimbursement for stop-loss claims and high-cost items
    - Appropriateness of the denial of services as non-covered, medically unnecessary or provided without proper pre-authorization or referral
    - Appropriate reimbursement (usual and customary) rates for non-contracted providers
- Claims in dispute have included claims and capitation payments for commercial, Medicare and Medicaid members. In each case, the following primary tasks were performed:
    - Review of deposition testimony, contracts, contemporaneous correspondence regarding contract negotiations and other documents produced through discovery
    - Assessment of opposing party's damages claim and supporting documentation
    - Identification of "at issue" claims populations and selection of one or more statistically valid sample(s) of claims
    - Re-adjudication of sample claims and extrapolation to the population(s) of "at issue" claims
    - Provision of other litigation support, such as providing advice on depositions, production of an expert report and settlement negotiations

Employer/Payer Disputes

- Managed two projects involving self-funded employers in litigation with their third party administrators (TPAs) over the administration of the employers' health benefits programs. Primary allegations in each case related to the improper payment/overpayment of fee-for-service claims and failure to adhere to agreed upon utilization review and coordination of care programs (also resulting in the alleged overpayment of claims for healthcare services). Key engagement tasks on these cases included:
    - A comprehensive review of the TPA's utilization review and coordination of care programs and comparison of those programs to industry standards and the TPA's contractual obligations to the employer
    - Analysis of the accuracy of claims payments using a statistical sampling approach
    - Reconciliation of member enrollment

- Review of historical claims payment and claims lag data to determine whether claims were paid and reported to the employer in a timely manner and whether premiums charged by the TPA reflected actual experience
- The review, analysis and rebuttal of the adverse party's expert sampling and analysis to quantify claims overpayments
- Compilation of results and findings into an expert report

Employee/Hospital Breach of Contract Dispute

- Led a project team working with counsel for a hospital in Texas that was sued by the physician group formerly under contract to staff the hospital's Emergency Department (ED). Allegations in the case revolved around the hospital's alleged wrongful termination of the contract and its alleged refusal to allow the ED physicians to bill for interpretations of radiologic (x-rays, ultrasounds, EKGs) tests. The project team accomplished the following:
  - Reviewing all medical records from the ED group's files to identify whether a radiologic exam was ordered, whether a written interpretation existed in the records, and who performed the interpretation
  - Obtaining an electronic file of all billings made by the ED group during its tenure at the hospital, converting the file to a usable format and reviewing the billing records to identify billings for interpretations
  - Comparing the electronic billing records to a hand-written log of interpretations billed that was prepared by the ED group as evidence of its alleged lost profits
  - Illustrating that the hand-written log contained significantly more entries and dollars than the actual electronic billing records and quantifying the overstatement
  - Participating in the preparation of fact witness and expert depositions
  - Preparing and submitting an expert report of findings and providing expert testimony

Criminal Prosecution of Health Plan Executives and Follow-on Civil Litigation

- Led an engagement team providing managed care industry and financial expertise to defense counsel in matter involving allegations of Medicaid managed care fraud. Key engagement activities included: analyzing data supporting annual medical loss ratio (MLR) calculations, analyzing encounter data submissions, and performing industry related research to assist counsel with identifying case facts and industry standards. Also supported the testifying expert in the case, who was another BRG Healthcare Director.

Medicaid Rate Setting Dispute

- Led a project team working with counsel for a hospital system in Texas that claimed the State Medicaid Agency's rate setting process for inpatient hospital reimbursement was violating state statute and rules by not allowing certain claims incurred during the base fiscal year to be included in the calculation of the hospital's costs. Each hospital's average cost per case was the primary input for calculating Medicaid reimbursement levels for inpatient services. Also performed a comparative analysis of the claims that had been included in and excluded from the average cost calculation to determine whether the exclusion of the claims at issue resulted in an understatement of average costs. Testified to the results of the analysis in the District Court of Travis County, Texas.

Clinical Laboratory Litigation

- Managed an engagement for a clinical laboratory involved in multiple class action litigations regarding its billing practices. Responsibilities included:
    - Collecting and analyzing the provider's billing data
    - Creating an original database that catalogued tens of thousands of hard copy remittances Performing analyses to determine the provider's possible exposure to the classes
    - Providing opinions and preparing documentary evidence on class certification issues
    - Advising counsel with settlement negotiations

Long-Term Care Pharmacy Purchase Price Dispute

- Managed and engagement for an independent long-term care pharmacy in a legal dispute with its purchaser over the final determination of the purchase price that was based on the pharmacy's net earnings in the first two years after purchase. Engagement activities included assisting the pharmacy client with assessing its position in the dispute and preparing information relevant to that position to be provided to an independent third party mediator. The key issue in the dispute regarded the price at which the pharmacy could obtain generic pharmaceuticals and the impact those prices had on its net earnings.

Product Liability Litigation

- Led a team that advised a joint defense group in evaluating, critiquing and performing analyses on Plaintiff expert reports and economic damage models related to the healthcare costs associated with smoking for several large product liability cases brought against tobacco companies. Responsibilities included:
    - Advising counsel with preparing discovery requests and deposition questions
    - Performing analyses on hundreds of millions of healthcare claims to assess liability and damages issues
    - Assessing Plaintiff damages models for erroneous/unreasonable/aggressive assumptions and estimates
    - Advising counsel regarding the fundamentals and assumptions of the damage models, which involved complex statistical analyses and were based on large, detailed electronic claims data sets and survey data
    - Recalculating the damages models to test the accuracy of the Plaintiffs' assumptions and calculations
    - Developing analyses demonstrating the net effect of changing the assumptions of the calculations and/or cofounding variables

Operational, Compliance, Fraud and Risk Management Consulting

MRA Operational and Compliance Risk Assessments

- Worked with multiple MAOs, physician organizations, private equity firms and their outside counsel to assess current Medicare Risk Adjustment practices, policies and procedures in comparison with industry standards. Engagement tasks have included:
    - Reviewing relevant program documents, including policies and procedures, job descriptions, coder and provider training and educational materials, and vendor contracts, among others
    - Interviewing management, coders, providers and vendors to understand current practices
    - Performing coding validation reviews of medical charts
    - Reporting to clients on best practices and potential regulatory compliance risk areas

Medicare Advantage Organization MRA Risk Management

- Worked with multiple MAOs and their outside counsel to evaluate regulatory compliance risk regarding its policies and practices for conducting medical record reviews and submitting risk adjustment data to CMS under the MRA program, and assisted with redesigning processes to mitigate the identified risks

Managed Care Organization Operational Assessments

- Worked with multiple managed care organizations to assess current and historic operations by performing extensive analysis of internal control procedures. Engagements included the selection and audit of statistically valid samples of claims that have been adjudicated by the payers. Responsibilities included:
    - Identifying relevant populations of claims to be tested and generating statistically valid random samples from these populations
    - Testing claims processing timeliness and accuracy and quantifying errors identified in claims tested
    - Developing extrapolation methodologies to calculate total under- or overpayments within each population of claims
    - Working in conjunction with multiple actuarial firms to verify the reasonableness of the "incurred but not reported" (IBNR) liability

Fraud Risk Assessment and Fraud Management Program Strategy Design

- Worked with a Ministry of Health in a Canadian province to assess its fraud risk management program and develop recommendations for a go-forward program strategy. Key engagement tasks included:
    - Gaining an understanding of each area within the Ministry with responsibility for fraud prevention, detection and investigation
    - Assessing the effectiveness of the current fraud management program in terms of responsibilities, resources, controls and data analytics capabilities
    - Developing a comprehensive strategy and recommendations for enhancing the current fraud management program based on findings from the risk assessment and knowledge of leading practices in other countries/jurisdictions

EDUCATION

- B.B.A., Accounting University of Wisconsin-Madison, 1993

PRESENT EMPLOYMENT

- BRG, LLC, Tampa, FL, 2010 to present
  Managing Director, Health Analytics

PREVIOUS POSITIONS

- Deloitte, Tampa, FL, 2007 to 2009
  Principal

- Navigant Consulting, Inc. (now Ankura), Tampa, FL, Washington, DC, Atlanta, GA, 1994 to 2007
  Director (last position)

LICENSES/CERTIFICATIONS

- Certified Public Accountant (CPA), licensed in the State of Wisconsin
- Certified in Financial Forensics (CFF)
- Chartered Global Management Accountant (CGMA)

PROFESSIONAL AFFILIATIONS

Prior

- Healthcare Businesswomen's Association
- Women Business Leaders of the U.S. Health Care Industry Foundation

Present

- American Institute of Certified Public Accountants
- Wisconsin Institute of Certified Public Accountants
- American Health Lawyers Association
- American Bar Association, Health Law Section

KEY SPEAKING ENGAGEMENTS

- 2024 BCBS Law, Audit, Compliance & Ethics Conference. "False Claims Act Risk and the RADV Final Rule." May 21, 2024.
- 2023 American Conference Institute Legal, Regulatory and Compliance Summit on Medicare Advantage. "Emerging Enforcement and Investigation Trends in Medicare Advantage." November 2, 2023, Nashville, Tennessee.
- 2022 American Bar Association Managed Care Institute. "Managing Managed Care False Claims Act Risk." December 14, 2022, Washington DC.
- 2022 American Conference Institute Legal, Regulatory and Compliance Summit on Medicare Advantage. "Forecasting Future Enforcement: Implications for Legal and Compliance." October 13, 2022, Nashville, Tennessee.
- 2022 BCBS National Summit. "Medicare Advantage: Reimagining Risk Mitigation for Medicare Advantage Organizations." May 4, 2022, Orlando, Florida.
- 2021 American Health Law Association. "Fraud and Abuse & Managed Care: Key Issues and 2021 Updates." November 4, 2021 [Podcast].
- 2020 American Health Law Association Annual Meeting. "Managed Care Compliance and Enforcement – What You Don't Know, Will Hurt You." June 30, 2020 [Virtual].
- 2020 Health Care Compliance Association Managed Care Compliance Conference. "Risk Adjustment Compliance: Can You Afford the Risk?" January 28, Orlando, Florida.
- 2019 American Conference Institute Managed Care Disputes and Litigation. "Medicare Risk Adjustment: Understanding the Implications of the Latest Enforcement and Litigation Developments." May 16, Chicago, Illinois.
- 2019 Health Care Compliance Association Managed Care Compliance Conference. "Medicare Risk Adjustment: Resources on Emerging Risk Areas." January 29, Orlando, Florida.
- 2018 American Conference Institute Managed Care Disputes and Litigation. "Medicare Risk Adjustment Landscape: Learning from Today's Environment to Prepare for What Comes Next." May 17, Philadelphia, Pennsylvania.
- 2017 American Conference Institute Managed Care Disputes and Litigation. "Spotlight on Medicare Risk Adjustment." May 2, Philadelphia, Pennsylvania.
- 2017 National Association of Criminal Defense Lawyers White Collar Criminal Defense College. "Hiring Experts and Expert Witnesses." March 17, Gulfport, Florida.
- 2015 National Association of Criminal Defense Lawyers White Collar Criminal Defense College. "Hiring Experts and Expert Witnesses." March 13, Gulfport, Florida.

- 2014 American Health Lawyers Association Fraud and Compliance Institute. “The Compliance Risks and Rewards of Big Data in Healthcare.” October 7, Baltimore, Maryland.
- 2009 ICLE Southeastern Health Care Fraud Institute. “Office of Inspector General Initiatives.” December 17, Atlanta, Georgia.
- 2009 Skadden Arps/Deloitte CLE Event. “Weathering the Storm: Managing Litigation and Enforcement Risks in the Global Pharmaceuticals, Medical Devices and Life Sciences Markets.” June 4, New York, New York.
- 2009 Baker Donelson/Deloitte CLE/CPE Event. “Storm Clouds Over Health Care: Preparing Your Company to Weather a Government Investigation in the New Enforcement Environment.” April 28, Nashville, Tennessee.
- 2008 ICLE Southeastern Health Care Fraud Institute. “Corporate Compliance - Reducing Exposure to Severe Sanctions.” December 18, Atlanta, Georgia.
- 2008 Deloitte College for Health Sciences. “The Shifting Landscape of Health Care Fraud and Regulatory Compliance.” October 14, Phoenix, Arizona.
- 2008 L.E.I. National CLE Conference, Health Law Program. “The Role of Counsel and Consultant in Applying Forensic Analysis During Government Investigations and Commercial Disputes.” January 9, Vail, Colorado.
- 2007 Deloitte College for Life Sciences & Health Care. “Top Investigation, Litigation and Dispute Risks: What You Need to Know and Do.” October 2, Hollywood, Florida.
- 2006 Akerman Senterfitt’s Annual Health Care Meeting. “Health Care Litigation Trends.” August 18, Orlando, Florida.
- 2006 Florida Bar Association Annual Meeting – Health Law Section. “Health Care Litigation Trends.” June 23, Boca Raton, Florida.