Curriculum Vitae

Richard Merino
BRG, LLC
Charlotte, NC

Direct: 920.505.9199
rmerino@thinkbrg.com

SUMMARY

Richard Merino is a Managing Director in the Health Analytics Practice at BRG. He is an experienced healthcare operations, compliance and litigation support professional that has focused his career on the development, evaluation, implementation and evaluation of operational improvement initiatives, litigation support, investigation and risk management techniques for all types of healthcare entities.

Richard previously served as a senior Managing Director in Ankura's Healthcare market segment of the Disputes & Economics practice area. He also served as Managing Director in PwC's Risk Assurance segment and was responsible for the national Healthcare Compliance practice. He has more than 25 years of experience in operations, regulatory compliance, process improvement and disputes within the Healthcare industry focusing on Medicare and Medicaid plan sponsors, commercial managed care entities, hospital and provider practice organizations, pharmacy benefit managers and other healthcare related entities.

Richard has managed and directed experienced teams in the preparation for and participation in numerous regulatory audits performed by governmental agencies including The Centers for Medicare & Medicaid Services (CMS), state Medicaid departments, and the Office of Inspector General (OIG). Richard has conducted operational risk detection, management, and remediation activities on behalf of managed care and governmental health plans and has successfully developed and executed numerous corrective action plans.

Richard has worked with and on behalf of health plan Special Investigations Units (SIU) and assisted in the development of programmatic, data driven processes to identify aberrant claims and billing patterns and have advised plans on the processes to undertake in the event of potentially fraudulent provider behavior. Richard has reviewed claims and other data from hospitals, physicians, lab and drug entities for potential fraud, waste or abuse situations.

Richard has led multiple engagements related to governmental enforcement actions including those initiated by the Office of Inspector General (OIG) and the Department of Justice (DOJ), including allegations of fraud, non-compliance, and other enforcement actions.

Richard has been a faculty speaker at several industry conferences and is an author of numerous industry-related articles and reference publications.

In connection with disputes between healthcare entities, Richard has assessed contract compliance and quantified the financial impact of potential underpayments or overpayments related to those contractual provisions. He has worked with providers in a consulting expert capacity in several litigations. Many of these have dealt with disputes over claims payment, processing or denials in connection with contractual terms between the parties. These disputes have also dealt with the appropriate reimbursement levels for non-contracted entities and the concepts of usual, reasonable and customary charges and use of Chargemaster price lists by hospital systems.

Richard has been accepted as an expert witness in federal and state civil and criminal divisions as well as arbitration tribunals. He has testified in matters involving managed care entities – including those with governmental contracts – hospital systems, laboratories, and pharmacy providers. His expert testimony has been at the forefront of major healthcare matters, including Value Based Care arrangements, specialty pharmacy, utilization management, and clinical quality.

EDUCATION

J.D.	Mississippi College School of Law
B.A.	Florida State University

PRESENT EMPLOYMENT

BRG, Charlotte, NC, 2025 - Present
Managing Director

PREVIOUS POSITIONS

ANKURA, 2019 - 2025
Senior Managing Director

PRICEWATERHOUSECOOPERS, 2015 - 2019
Managing Director

FTI CONSULTING, 2009 - 2015
Managing Director

HURON CONSULTING GROUP, 2005 - 2009
Senior Director

AREAS OF EXPERTISE

- Designated testifying and consulting expert in healthcare disputes
- Fraud, Waste and Abuse Program development, implementation and execution
- Regulatory Audit Preparation, Support and Remediation
- Healthcare System Merger and Acquisition Due Diligence and Integration
- Managed Care Operations and Process Evaluation and Improvement Experience

PROFESSIONAL EXPERIENCE

Government Contracting Experience

- Performed full RFP and contracting review for a Tricare contractor related to a jurisdictional bid for health and pharmacy services. This included a full analysis and review of claims processing, membership enrollment, invoicing, pharmacy and provider contracting services.
- Review and analysis of contractual partners for a Tricare contractor to perform certain claims and financial reconciliation functions on behalf of the contractor.
- Performed the full drawdown and exit of an outgoing Medicare Administrative Contractor (MAC) for Jurisdiction 5. This included full runout of claims and financial liabilities and reporting to CMS and other regulatory entities as well as data conversion and transfer to the incoming contractor.

Managed Care Operations and Process Evaluation and Improvement Experience

- Assisted an ACA exchange health plan set up their risk adjustment programming particularly how it needed to differ from the traditional MA approach.
- Worked with an ACA exchange plan's government programs and internal audit teams to do audits of the risk adjustment data, programs and chart reviews where necessary.
- Performed numerous operational reviews involving all managed care plan functions including claims processing, enrollment, customer service including complaints, appeals and grievances, clinical operations, pharmacy services and delegation oversight.
- Conducted end to end process reviews of pertinent plan functions and have provided findings and recommendations for improvement and has overseen the implementation of corrections.

- Performed claims processing and enrollment system reviews including overseeing associated system conversions.

- Worked with senior management and departmental leadership to identify and correct and process deficiencies.

- Performed contract compliance audits and reviews on behalf of health plans and for delegated entity vendors in the areas of utilization/disease management, dental, vision, behavioral health, eligibility and claims processing.

- Performed audits, compliance program reviews and operational evaluations of all sizes of Pharmacy Benefit Managers including each of the largest PBM entities.

Compliance program and Investigations

- Developed, implemented and tracked performance of corporate compliance programs for large healthcare providers, hospital systems, labs and pharmaceutical companies that encompassed acute care, research and provider operations.

- Developed full risk assessment and audit programs for compliance operations to identify and mitigate provider compliance risk.

- Presented to full Boards of Directors and executive level staff as well as Audit and Compliance Committees of payers, providers and hospital systems to perform training and report on potential compliance risk.

- Managed Independent Review Organization (IRO) engagements for both providers and payers under Corporate Integrity Agreements (CIAs) related to findings of violations for False Claims Act, Anti-Kickback (Stark) Act and other established regulations.

- Communicated directly with regulatory agencies including CMS, OIG and DOJ related to compliance performance of compliance programs and progression under CIAs and other enforcement actions.

- Performed compliance reviews for state Medicaid providers.

- Performed and taken part in several investigations to uncover potential fraud, waste and abuse and other compliance violations for Medicaid providers.

- Served as an interim Part D Compliance Officer

- Prepared numerous MA, Part D, and SNP applications

- Managed turnaround and Medicare compliance activities for health plans including Medicare demonstration projects.

- Performed compliance program reviews and implemented compliance programs for managed care plans, pharmaceutical manufacturers, provider practices and hospital systems.

- Implemented full corporate compliance programs for managed care payors and providers based upon the seven elements of an effective compliance plan codified in the Federal Sentencing Guidelines.

- Established and overseen all regulatory complaints, appeals and grievance procedures of managed care health plans and has been party to several market conduct examinations by state insurance departments regarding these processes.

- Worked with plans related to the proper processing of claims and utilization management for specialty services including home health, nursing home, post-acute rehab and Skilled Nursing Facility ("SNF") encounters.

- Performed Compliance Effectiveness Measurement Assessments and implemented Corporate Compliance Programs for numerous hospitals and Managed Care plans and pharmaceutical manufacturers.

- Worked with and on behalf of health plan Special Investigations Units (SIU) and assisted in the development of programmatic, data driven processes to identify aberrant claims and billing patterns and have advised plans on the processes to undertake in the event of potentially fraudulent provider behavior.

Medicare and Medicaid Experience

- Performed a full privileged investigation and review of the Medicare Advantage marketing and Sales as accreted through contracted agents, brokers and Field Marketing Organizations ('FMOs") for the largest managed care payer in the nation.

- Performed full Medicaid contract and EQRO reviews in multiple states for one of the largest combined Medicaid managed care entities in the program.

- Managed and administered the internal compliance audit function for the largest Medicare Advantage and Part D health plan in the nation. This work included extensive interaction with the senior management of the plan as well as CMS Central and Regional Office.

- Assisted a California Medicare and Medicaid demonstration plan with a claims processing system transition that involved multiple service lines and provider types.

- Performed an initial record retention review for a California Medicare and Medicaid demonstration plan to determine their ongoing needs.

- Managed and directed the entire internal compliance audit work plan for one of the largest Medicare Advantage plans in the program.

- Performed operational and compliance audits of large Medicaid managed care plans.
- Reviewed dual eligible and Special Needs Plans in the Medicare Advantage program.
- Performed and managed mock audits and other reviews of Medicare Advantage and Part D plan sponsors that included reviews of their delegated entities including PBMs.
- Managed reviews of PBM operations related to Part D contractor functions including the submission and validity of Prescription Drug Event (PDE) data and claims payment accuracy.
- Have reviewed Part D plan and PBM administration to focus on issues such as Part B v D determinations and the proper categorization and processing of claims related to specialty or physician-administered drugs.
- Performed operational reviews for large Medicare contractors in charge of Part A and Part B claims adjudication.
- Managed a large corrective action plan for a Medicare contractor that involved the historical and ongoing operation of that shared claims processing system including the evaluation of system edits and audits.
- Communicated directly with CMS senior plan personnel on the activities of a large Medicare contractor included in a CMS/DOJ investigation.
- Managed qui tam litigation defense for a large Medicare contractor involving the use of the shared claims processing system.
- Reviewed the IT and systems functionality of claims and enrollment processing at multiple Medicare Advantage and Part D health plan sponsors.
- Consulted for large health plan clients for their initial application to the Medicare Advantage program and implemented corrective actions necessary for optimal positioning of the plan.

Hospital System and Provider Operations

- Directed a large-scale due diligence and integration of a multi-hospital, multi-disciplinary provider practice and medical school entity with a large Southeastern not-for-profit hospital system. This integration involved finance, care delivery, managed care, medical school, physician practice, IT and compliance assessments.
- Directed an acquisition of a managed care company by a physician practice management entity that involved several issues pertaining to operational setup and establishment of financial and payer controls.
- Performed a large scale operational and risk assessment of a not-for-profit multistate hospital system based in California. This assessment involved hospital, physician, laboratory and research operations of

the system. Results of the assessments were presented to the Board over multiple sessions and additional work product to cure issues were procured.

- Assisted in the bankruptcy receivership of a large Independent Physician Association (IPA) including review of contractual relationships and draw down of operations at the direction of the Federal Bankruptcy Court.

- Directed the review of contractual allegations made by a client hospital system against a large managed care payor organization over the reimbursement methodology and denial rationale for certain contracted services performed by the health system.

- Assisted in the development of expert witness reports for a litigation matter between a Utah hospital facility and a managed care payor regarding the reimbursement of NICU claims.

- Performed a review of Usual, Customary and Reasonable charges related to a dispute between a hospital system and a managed care payor.

- Performed a review of Chargemaster and other facility systems to assist in the determination of appropriate charges for a non-contracted facility.

- Directed and managed a review of hospital billing and utilization data for a midsized hospital system in response to a *qui tam* allegation of overbilling and inappropriate referral activities.

- Directed and managed a review of Electronic Health Record (EHR) systems in conjunction with the eligibility and meaningful use standards of the Federal EHR Incentive Program.

EXPERT WITNESS MATTERS

(1) TMG v. UnitedHealthcare, 2014

(2) MCIC v. United Healthcare, 2015

(3) United States v. Juan Camilo Perez Buitrago, 2021

(4) Community Hospital of the Monterrey Peninsula v. Anthem, 2021

(5) Erlanger Health System v. AmeriChoice, 2022

(6) Salinas Valley Memorial Hospital v. Anthem, 2022

(7) New Mexico Oncology & Hematology Consultants v. Presbyterian Healthcare, 2022

(8) United Allergy Services v. Blue Cross Blue Shield of Louisiana, Blue Cross Blue Shield of Kansas and Humana, 2023

(9) Mansour v. Freedom Health, Inc and Physician Partners, L.L.C., 2024

(10) Crossbreeze v. Sunshine Health Plan, 2024

(11) Bridges Health Partners v. Aetna Health, Inc., 2025

(12) St. Vincent Hospital v. Blue Cross Blue Shield of Arkansas, 2025

PUBLICATIONS

(1) "Regulation of Medicare Part D Plans" Chapter Author: Chapter 10 "Coverage Determinations, Appeals and Grievances", Thomson Reuters; 2015

(2) "Medicare audits: CMS Imposes Corrective Action Plans on Sponsor's Faults" Managed Healthcare Executive, September 2008

(3) "Medicare Advantage and Part D Final Rule" HCCA Compliance Today, April 2008

(4) "CMS Audit Activity is Fierce: Is your Medicare Advantage and Part D Program Prepared?" HCCA Compliance Today, November 2007

PRESENTATIONS AND SPEAKING ENGAGEMENTS

(1) "CMS Appeals Timeliness Monitoring: How to Prepare for the New Annual Reviews" HCCA Managed Care Compliance, February 2018

(2) "Compliance Implications of the Medicare-Medicaid Dual Eligible Demonstration Program", Managed Care Compliance Conference, Health Care Compliance Association, February 2015

(3) "Mastering the Gold Standard of Medicare Compliance: Appeals and Grievances" Medicare Compliance Summit, Financial Research Associates, November 2008

(4) "Preparing Your Plan for the Government's Medicaid Integrity Program" 2008 Medicare and Medicaid Conferences, America's Health Insurance Plans (AHIP), September 2008

(5) "Structuring Seamless Internal Auditing Programs" Medicare Compliance and Operations Summit, Financial Research Associates, July 2007

(6) "Pharmacy Audits: What are PBMs Doing?", Medicare Part D Compliance Conference, Health Care Compliance Association, December 2007

(7) “How to Effectively Structure an Internal Audit”, Medicare Compliance Challenges, Financial Research Associates, July 2007