Wayne T. Gibson

Senior Managing Director
Health Solutions

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Education

B.S., Environmental Science, College of William and Mary

M.A., Economics, University of Delaware

Associations

American Bar Association, associate member

American Health Lawyers Association, member (non-atty)

CFA Institute, member

HealthCare Financial Management Association member

Health Care Compliance Association, Member

Wayne Gibson has 24 years of experience applying economic and financial modeling, data-intensive analysis, and complex claims analyses across numerous industries and in a variety of operational, dispute and compliance matters. He has assisted health plans, providers, pharmaceutical manufacturers and PBMs with in a variety of matter types including operational improvement and compliance consulting, nationwide class-action litigation, Medicare and Medicaid false claims and sales and marketing investigations, investigations by other government agencies, and arbitration matters

Mr. Gibson has extensive experience with operational improvement and compliance assessments. He assisted with Medicare Advantage plans, ACA exchange-based plans, trading partners/vendors, and providers under risk contracts in an end to end assessment and redesign of workflows and data flows, policies and procedures, controls, reporting and forecasting related to their Medicare Advantage and risk adjusted populations. He has also performed reviews of systems and programming logic used to filter encounters to assess compliance with Medicare Advantage and Managed Medicaid requirements. He worked with clients to develop and implement interim and 'bridge' applications that provided added functionality in managing populations subject to risk adjustment and supported plans in RADV and other regulatory reviews.

He has also done work in Medicare and Medicaid Investigations. He assisted a variety of clients including health plans, pharmaceutical manufacturers, institutional providers, diagnostic lab testing companies, and their outside counsel in responding to governmental investigations and in conducting internal investigations related to Medicaid and Medicare false claims and fraud and abuse issues as well as how these issues may impact statutory and SEC reporting. These investigations encompass issues such as reimbursement, pricing, Medical Loss Ratios and cost reporting, and sales and marketing.

In regard to compliance and operational reviews, he assisted a variety of clients with compliance reviews related to Medicare Advantage, Fee for Service Medicare and Medicaid programs. He has also performed other contractually mandated reviews, and operational assessments of controls, data and information systems, and relationships with third parties/sub-contractors.

While working on litigation and commercial disputes (healthcare and other industries), he assisted a variety of clients and their outside counsel in defense of nationwide class-action matters, federal and state court litigation, international arbitration, and arbitration and mediation matters. He also developed and submitted expert reports on damages in a number of forums and has testified in arbitrations.