Annual Fraud, Waste, and Abuse & Pharmacy Compliance Training

Revised 2023

What do you know? (Pre-Test)

1. What is not an element of an effective compliance program:
   A. Written policies
   B. A designated Compliance Officer
   C. Effective training and education
   D. Not having a reporting mechanism

2. Fraud requires both intent and knowledge?

   True or False

3. What does HIPAA stand for?
   A. Health Insurance Prescription and Account Access
   B. Health Insurance Portability and Accountability Act
   C. Health Information and Prescription Accountability Act

4. There are both civil and criminal penalties to employees as well as companies who commit fraud , waste or abuse?

   True or False

5. If I see something I should say something?

   True or False

Why do we have a Compliance Program?

- Our business is highly regulated by both federal & state governments.
- Compliance Programs reduce risk & promotes ethical behavior by employees.
- Compliance Programs improve quality of services, efficiency and create positive workplace environments.
- Compliance Programs can prevent the Company from paying fines, penalties or even criminal prosecution.
- Failure to follow laws, regulations, and policies can result in serious consequences.

Why Do I Need Training or Re-training?

- Every year billions of dollars are improperly spent because of FWA (Fraud, Waste, and Abuse). It affects everyone – including you. This training will help you detect, correct, and prevent FWA. You are part of the solution. Medicaid and Medicare require companies to retrain their employees every year.
- Combating FWA is everyone's responsibility! As an individual/employee who provides services for Medicaid/Medicare clients, every action you take potentially affects the Program.
- "All Affected Individuals" from the Board, executives, employees, contractors, agents and vendors have an affirmative obligation to report fraud waste and abuse.
- This is just a review of the basics.
- An effective compliance program demonstrates our commitment to reliability, honesty, and business integrity.
- This course explains the activities of greatest concern to the government and provides examples of situations that can lead to charges of fraud or abuse.

EXPECTATIONS

- Culture: To create and maintain a work environment in which ethical concerns can be raised and openly discussed.
- Training, education and retraining yearly on preventing FRAUD, WASTE and ABUSE.
- To prevent improper conduct, whether intentional or not, from occurring.
- To also detect and prevent patterns of improper conduct, or the appearance of such improper patterns, from developing.

- BrightSpring Health Services and PharMerica, including its subsidiaries, are committed to conducting its business ethically and in line with good business practices. It is the company's policy to comply with all applicable federal and state compliance laws, rules, and regulations including anti-kickback laws, and to require all affected individuals; executives, supervisors, managers, any employees, contracted agents, consultants, and business partners who work on BrightSpring's behalf to comply with these same laws and practices.
- Healthcare providers are mandated to comply with section 6032 of the Federal Deficit Reduction Act of 2005 ("DRA"). Providers are required to educate their staff and contractors about the False Claims Act as well as the provider's policies and procedures for detecting and preventing fraud, waste and abuse.

Mandatory Compliance Requirements

- Effective April 2020, for New York State (NYS) Social Services Law (SSL) §363-d, and effective December 28, 2022, for the corresponding regulations at 18 New York Codes, Rules and Regulations (NYCRR) Subpart 521-1, NYS Medicaid providers shall adopt, implement, and maintain effective compliance programs aimed at detecting fraud, waste, and abuse in the NYS Medicaid program. All NYS Medicaid providers subject to the provisions of Public Health Law (PHL) Articles 28 or 36, providers subject to the provisions of Mental Hygiene Law (MHL) Articles 16 or 31, Medicaid Managed Care (MMC) providers of Managed Long Term Care (MLTC) Plans [collectively, Medicaid Managed Care Organization (MMCOs)], and those providers for which the NYS Medicaid program "constitutes a substantial portion of business operations," are required to have an effective compliance program.
- The Office of the Medicaid Inspector General (OMIG) defines "substantial portion of business operations" as claiming or receiving $1,000,000 or more in the aggregate in a consecutive 12-month period, directly or indirectly, from the NYS Medicaid program. OMIG has the responsibility under SOS §363-d and Subpart 521-1 to determine if compliance programs meet the requirements of the law and regulation. An "effective" compliance program is defined in Subpart 521-1 as a compliance program adopted and implemented by the required provider that, at a minimum, satisfies the requirements of Subpart 521-1 and that is designed to be compatible with the provider's characteristics.

Fraud, Waste, and Abuse: Differences & Examples

- There are differences among fraud, waste, and abuse.
- **Fraud requires intent** to obtain payment and the **knowledge** the actions are wrong.
- **Waste and Abuse** may involve obtaining an improper payment or creating an unnecessary cost to the Medicare / Medicaid Program but **do not require the same intent and knowledge**.

Examples of actions that may constitute Medicaid/Medicare Fraud include:

- Knowingly billing for services not furnished or supplies not provided, including billing Medicare for appointments the patient failed to keep,
- Billing for nonexistent prescriptions, and/or,
- Knowingly altering claim forms, medical records, or receipts to receive a higher payment.

Examples of actions that may constitute Medicaid/Medicare Waste include:

- Conducting excessive office visits or writing excessive prescriptions,
- Prescribing more medications than necessary for treating a specific condition, and/or,
- Billing an incorrect day supply resulting in the patient receiving a larger quantity than allowed.

FWA – Fraud, Waste and Abuse

Fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program. In other words, fraud is intentionally submitting false information to the Government or a Government contractor to get money or a benefit.

Waste includes practices that, directly or indirectly, result in unnecessary costs to the Medicare / Medicaid Program, such as overusing services. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.

Abuse includes actions that may, directly or indirectly, result in unnecessary costs to the Medicare / Medicaid Program. Abuse involves paying for items or services when there is no legal entitlement to that payment, and the provider has not knowingly or intentionally misrepresented facts to obtain payment.

Examples of FWA

Examples of actions that may constitute Medicaid/Medicare Abuse include:

- Unknowingly billing for unnecessary medical services,
- Unknowingly billing for brand name drugs when generics are dispensed,
- Unknowingly excessively charging for services or supplies, and/or
- Unknowingly misusing codes on a claim, such as upcoding or unbundling codes.

To Understand and Detect FWA, You Need to Know the Law(s).

False Claims Act (FCA)

The civil provisions of the FCA make a person liable to pay damages to the Government if he or she knowingly:

- Conspires to violate the FCA,
- Includes making or using a false statement,
- Makes or uses a false record or statement supporting a false claim,
- Carries out other acts to obtain property from the Government by, misrepresentation,
- Conceals or improperly avoids or decreases an obligation to pay the Government
- Presents a false claim for payment or approval.

Liability may include, but not be limited to

- Repayment of up to three times the government's damages plus a penalty linked to inflation,
- Criminal felony to submit a false claim for payment from Federal funds - Medicare, Medicaid, TRICARE, Federal Employee Program (FEP), grants, etc.

False Claims Act (FCA) Example

News: 5/2021

https://www.justice.gov/usao-ndga/pr/alixarx-llc-agrees-pay-275-million-resolve-allegations-it-improperly-dispensed

AlixaRx LLC agrees to pay $2.75 million to resolve allegations that it improperly dispensed controlled substances at long-term care facilities.

The Government resolved allegations that AlixaRx submitted false claims to Medicare for invalid emergency prescriptions. The Government also resolved claims that AlixaRx billed Medicare Part D for claims that had already been reimbursed through claims paid to long-term care facilities under Medicare Part A.

Rules, Laws, and Statutes: Qui Tam

A Qui Tam allows a private person (whistleblower) to file a lawsuit on behalf of the United States against those who have falsely or fraudulently claimed Federal funds.

- A whistleblower is a person who exposes information or activity that is deemed illegal, dishonest, or violates professional or clinical standards.
- Protected: Persons who report false claims or bring legal actions to recover money paid on false claims are protected from retaliation.
- Rewarded: Persons who bring a successful whistleblower lawsuit receive at least 15 percent, but not more than 30 percent, of the money collected.

More Rules, Laws, and Statutes: Health Care Fraud

Health Care Fraud Statute

- The Health Care Fraud Statute states, "Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice to defraud any health care benefit program … shall be fined under this title or imprisoned not more than 10 years, or both."
- Conviction under the statute does not require proof the violator had knowledge of the law or specific intent to violate the law.

Criminal Health Care Fraud

Persons who knowingly make a false claim may be subject to:

- Criminal fines up to $250,000 *(fine amounts subject to change),*
- Imprisonment for up to 20 years, and/or
- If the violations resulted in death, the individual may be imprisoned for any term of years or for life.

More Rules, Laws, and Statutes: CMP Law

Civil Monetary Penalties (CMP) Law

The Office of Inspector General (OIG) may impose civil penalties for several reasons, including:

- Arranging for services or items from an excluded individual or entity,
- Providing services or items while excluded,
- Failing to grant OIG timely access to records,
- Knowing of and failing to report and return an overpayment,
- Making false claims, and/or
- Paying to influence referrals.

More Rules, Laws, and Statutes: ACA

Affordable Care Act (ACA) of 2010 (Obamacare)

- Expanded the Recovery Audit Contractor (RAC) program to include Medicaid and Medicare Part C and D,
- Provided additional funds to fight FWA,
- Is expected to be budget neutral,
- Expects that FWA Recovery ≥ Enforcement Cost,
- Increased provider/supplier review,
- Includes site visits, background checks, licensure checks, fingerprinting,
- Stipulates that false applications may lead to exclusion from all Federal programs,
- May terminate Medicaid enrollment based on unpaid overpayments, and
- May suspend payments if fraud is suspected.

Exclusions/Providers not Allowed to Bill:

Exclusions

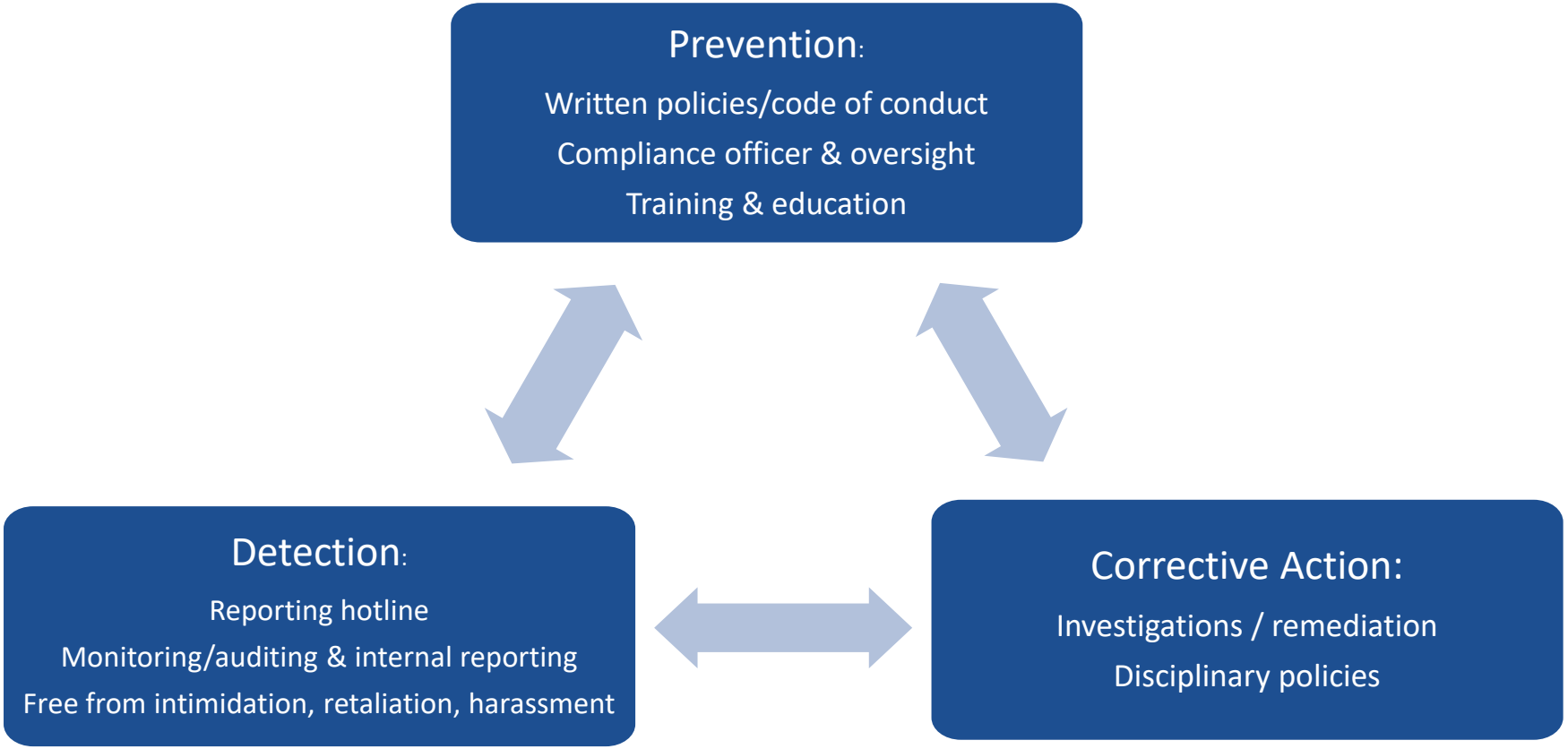
- No Federal health care program payment may be made for any item or service furnished, ordered, or prescribed by an individual or entity excluded by the OIG. The OIG has authority to exclude individuals and entities from federally funded health care programs and maintains the List of Excluded Individuals and Entities (LEIE).
- The U.S. General Services Administration (GSA) administers the Excluded Parties List System (EPLS), which contains debarment actions taken by various Federal agencies, including the OIG.

Basics of Fraud, Waste & Abuse

Prevent! Detect! Correct!

- We are required to adopt and implement an effective compliance program.
- CMS & OIG requires 7 core elements.
- Much more than just training! Everyone needs to do their job the right way every day.

The three purposes of a Compliance program: Prevention, Detection, and Correction



The seven Fundamental Elements of an Effective Compliance Program

An effective Compliance Program:

1. Has written policies, procedures and standards of conduct.
2. Designates a compliance officer and compliance committee.
3. Conducts effective training and education.
4. Develops effective lines of communication.
5. Enforces standards and have disciplinary policies.
6. Conducts and accesses internal monitoring and internal/external auditing.
7. Responds promptly to detected offenses and undertake corrective action.

Elements: Written Policies & Procedures

- BrightSpring and Pharmerica and its subsidiaries maintain a company Handbook, a company Code of Conduct, and policies and procedures available on the intranet. We have a Corporate Compliance Plan and committee.
- We have policies and procedures in place so that all employees know the right thing to do and can refer to such policies and procedures when questions arise.
- The Code of Conduct sets standards of conduct, summarizes basic rules and regulations that apply to our businesses, and gives guidance on raising compliance-related questions and concerns.

All employees must understand and follow the Code of Conduct in their everyday work.

Elements: Designation of A Compliance Officer

- There is a Chief Compliance Officer (CCO) who maintains the day-to-day responsibility for the corporate compliance program.
- The CCO has Compliance team members who are experienced, subject matter experts available to audit, monitor, assist, investigate, and educate employees on compliance issues and policies.
- The CCO routinely makes reports to the Board of Director's Quality and Compliance Committee and company Compliance Committees.

Elements: Training and Education

- Compliance Orientation Training occurs at initial hire for new hires.
- Compliance Training occurs annually for all employees.
- Some departments may get more detailed department-specific or role-specific training.
- Some employees may have additional compliance education based on audit or investigation findings.
- The Compliance Department distributes current information to employees regarding emerging trends, new laws and regulations, and compliance issues that affect them in their everyday work.

Elements: Communication Lines to the Compliance Officer

Communication is always available.

- The corporate HOTLINE numbers are:
  - BrightSpring: 1-866-293-3863
  - PharMerica: 1-800-793-7741
  - You may report anonymously.
  - Reports are confidential to the extent allowed by law.
  - Either line may be used.
- A compliance officer can be reached at 502.630.7023.
- All individuals are required to report suspected misconduct or possible violations of Federal laws, state laws, or the Corporate Compliance program. No retaliation, retribution, or intimidation will be tolerated for reporting potential issues.
- Employees are encouraged to report concerns through local chain of command, though the Compliance Department and Action Line are also avenues.
- Employees may contact the Compliance Action Line with good faith concerns regarding compliance issues.

Elements: Disciplinary Policies

Employees who are found to have violated the Code of Conduct, Company policies, or applicable laws or regulations will receive corrective action/discipline.

- Violation examples include, but are not limited to:
  - failure to report,
  - participating in non-compliant behavior,
  - encouraging, directing, facilitating, or permitting non-compliant behavior,
  - failing to detect and report a compliance violation.
- The discipline will be enforced fairly and firmly to violators at all levels of the organization.
- Corrective action/discipline should be proportional to the offense/infraction.
- HR Policy addressing Progressive Disciplinary Action provides details & guidance related to corrective action.
- All allegations and reports will be promptly and thoroughly investigated.

Elements: Auditing and Monitoring

The compliance program routinely assesses risks and develops a work plan to address risks identified through auditing and monitoring.

- Every month our company does a check for providers not allowed to bill; this includes a check on all affected individuals.
- Additional areas and audit prevention tools are available in the Corporate Compliance Plan such as:
  - Onsite master audits,
  - Focused audits, and/or
  - Review of publications issued by government regarding compliance rules or protocols that need to be implemented.
- Whenever a potential violation is discovered, staff is coached to prevent future issues.

Elements: Responding to Compliance Issues

- All FWA allegations and other compliance concerns will be logged and promptly be thoroughly investigation by the Compliance Department or other trained investigator.
- New policies and systems may be implemented to reduce the potential for recurrence.
- Additional education, auditing, and monitoring may be implemented.
- If overpayments are discovered, the proper steps will be taken for repayment during the appropriate time frame.

Office of Inspector General (OIG):

- The OIG: Oversight division of a federal or state agency aimed at preventing inefficient or unlawful operation and the integrity of the HHS (Health & Human Service) program.
- The OIG's list includes seven elements. It does not specifically cover non-intimidation / non-harassment.
- We want to make sure we have an effective compliance plan, so we do include nonretaliation and non-intimidation in our compliance plan.
- Some states include non-intimidation / non-harassment as an 8th element.
- Non-retaliation and non-intimidation are crucial elements of effective compliance programs. People will not participate if they fear they will be retaliated against for reporting potential issues.

So, What Next?

Correction

- Once fraud, waste, or abuse is detected, promptly correct it. Correcting the problem saves the Government money and ensures your compliance with Center for Medicare/Medicaid Services requirements.
- Develop a plan to correct the issue. Ask your organization's compliance officer about the development process for the corrective action plan. The actual plan is going to vary, depending on the specific circumstances.
- Design the corrective action to correct the underlying problem or root cause. that results in FWA program violations and to prevent future noncompliance.
- Tailor the corrective action to address the FWA, problem, or deficiency identified; Include timeframes for specific actions.
- Monitor corrective actions continuously to ensure effectiveness (Master, Focus, and self audits and RPD quarterly checklist).

Final Words

Our commitment to ethics & integrity begins by complying with laws, rules and regulations that apply to all our roles within the Company.

Ask yourself: "Is this something that I want my family to know I did or be reported by the local news?" If the answer is "No," then you may want to take a different action or ask a manager for help.

If you need help deciding whether an action of behavior by you or a coworker is ethical, please speak with your local management team or report to the Compliance Department or Compliance Hotline.

Non-Retribution / Non-Retaliation / Non-Intimidation

- Employees who bring forth their good faith concerns to the Compliance Department are protected from retaliation.
- Maliciously false accusations and repeated misuse of the Action Line will be addressed through corrective action.
- All affected individuals (BrightSpring Health Services, PharMerica, and its pharmacy subsidiaries), board members and executives, all employees and contractors/agents/vendors have an affirmative obligation to report any ethical misconduct or compliance concerns.
- Anyone who suspects noncompliance with any laws, rules, regulations, or policies must report their concerns to any of the following:
  - Chain of Command
  - Compliance Department
  - Compliance Action Lines:
    - BrightSpring: 1.866.293.3863 or PharMerica: 1.800.793.7741
  - Email
    - complianceteam@brightspringhealth.com or compliance@pharmerica.com

Other State Laws to Note

Doing business in NY requires additional compliance steps. See our website for the NY region compliance, As defined in the NY law and as practiced: Our companies will not intimidate or retaliate against any employee who brings to our attention in good faith participation:

1. an issue or concern including, but not limited to any action or suspected action taken by or within the company that is illegal, fraudulent or in violation of any Corporate Compliance Policy,
2. cooperating with or participating in the investigation of such,
3. assisting with or participating in self-evaluations, audits and/or implementation of remedial actions, and/or
4. reporting to appropriate regulatory officials.

No violation reported by an employee in good faith will be the sole reason for subjecting an employee to discipline. We maintain a written policy of Non-Retaliation in our company handbook, Corporate Compliance Plan, and Code of Conduct (NYS Labor Law 741 and 741).

Reporting to our Hotline can be anonymous and confidential 24/7 at 1-800-793-4471, or your local FWA Compliance Officer. All issues will be thoroughly investigated and tracked.

In addition, you can report to:

- CMS Hotline at 1-800-633-4227 or TTY 1-877-486-2048
- NYS OMIG at 1-877-873-7283
- notify in writing to NYS Department of Health, Corning Tower, Empire Plaza, Albany, NY 12237
- HHS and US DOJ at https://www.stopmedicarefraud.gov or 1-800-447-8477 or TTY 1-800-377-4950.

Compliance Action Line 24/7

COMPLIANCE ACTION LINE: 1-800-793-7741

Reporting Process

If you want to report a Compliance issue:

- First talk to your supervisor or local/regional management.
- If you are uncomfortable reporting to local management, tell a member of Compliance Department.
- Call the Corporate Chief Compliance Officer or leave a voice mail at:
  1-502-630-7023.
- Email compliance@brightspringhealth.com or compliance@pharmerica.com.
- Use state specific hotlines, if necessary.
- You can also leave a message with Medicaid Fraud at:
  - 1-877-87-FRAUD (37283) or
  - https://stopmedicarefraud.gov.

Call the Compliance Hotline at **1.866.293.3863**

Reports are confidential and anonymous, to the extent allowable by law, and NO RETALIATORY action will be taken against you for reporting an issue or complaint.

The PharMerica Compliance Team

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What Did You Learn? (Post-Test)

1. What is not an element of an effective compliance program:
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   B. A designated Compliance Officer
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   True or False

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What Did You Learn? (Post-Test Answers by Self-Score)

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