

FRAUD, WASTE & ABUSE COMPLIANCE TRAINING



COMPANY COMMITMENT & MANDATE

- BrightSpring Health Services and PharMerica, including its subsidiaries (collectively, the “Company”), 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.

BRIGHTSPRING COMPLIANCE LEADERSHIP TEAM

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VP HOSPICE COMPLIANCE

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COMPLIANCE

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.

DEFINITIONS

- **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.
- **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.

FRAUD, WASTE & ABUSE COMPLIANCE TRAINING

WHY DO WE HAVE A COMPLIANCE PROGRAM?

- 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.
- Our business is highly regulated by both federal & state governments.
- 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.
- An effective compliance program demonstrates our commitment to reliability, honesty, and business integrity.
- This information explains the activities of greatest concern to the government and provides examples of situations that can lead to charges of fraud or abuse.

MANDATORY 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 & ABUSE COMPLIANCE TRAINING

FRAUD, WASTE & ABUSE: DIFFERENCES & EXAMPLES

There are differences between 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.

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.

OFFICE OF INSPECTOR GENERAL (OIG)

- The OIG: is the 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 of an effective compliance program.
- We want to make sure we have an effective compliance plan, so we also include nonretaliation and non-intimidation in our compliance plan.
- People will not participate if they fear they will be retaliated against for reporting potential issues.
- We want our employees to "speak up".

LAWS TO BE FAMILIAR WITH:

- Stark Law
- False Claims Act (FCA), Federal Deficit Reduction Act
- Anti-Kickback Statute, Safe Harbors, and Qui Tam
- Health Care Fraud (HCF) Statute
- Civil Monetary Penalties (CMP)
- Criminal Health Care Fraud
- Affordable Care Act of 2010 (ACA)
- Program Fraud Civil Remedies Act (PFCRA)
- Health Insurance Portability and Accountability Act (HIPAA)
- Fraud Enforcement and Recovery Act (FERA)
- NYS Social Services Law (SSL) 363-d
- 18 NYCRR Subpart 521-1
- New York Social Service Law, New York Labor Law (especially 740 and 741)

FRAUD, WASTE & ABUSE COMPLIANCE TRAINING

FALSE CLAIMS ACT

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
- Up to triple damages
- Criminal felony to submit a false claim for payment from Federal funds – Medicare, Medicaid, TRICARE, Federal Employee Program (FEP), grants, etc.

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.

HEALTH CARE FRAUD (HCF) 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.

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
- Paying to influence referrals

FRAUD, WASTE & ABUSE COMPLIANCE TRAINING

AFFORDABLE CARE ACT (ACA) OF 2010

- 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
- May suspend payments if fraud is suspected

EXCLUSIONS / PROVIDERS NOT ALLOWED TO BILL:

- 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.

ANTI KICKBACK STATUTE

- Criminal law prohibits the knowing or willfull renumeration to induce or reward patient referrals
- Includes anything of value.
- Some safe harbors do exist. Ask the compliance department for additional guidance.

PHYSICIAN SELF REFERRAL – STARK LAW

- Prohibits physicians from referring patients to receive “designated health services” payable by Medicaid or Medicare from entities to which the physician or their immediate family has a financial relationship unless an exception applies.
- Contact the Compliance Department for additional information and clarification.

FRAUD, WASTE & ABUSE COMPLIANCE TRAINING

ELEMENT 1: 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.

ELEMENT 2: DESIGNATED COMPLIANCE OFFICER

- There is a Chief Compliance Officer (CCO) who maintains 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.

ELEMENT 3: TRAINING & 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.

ELEMENT 4: COMMUNICATION

- 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 in the event an employee is not comfortable reporting through local management.
- Employees may contact the Compliance Action Line with good faith concerns regarding compliance issues.
- Reporters may remain anonymous and reports are confidential to the extent allowed by law.

THE SEVEN CORE ELEMENTS OF AN EFFECTIVE COMPLIANCE PROGRAM

There are seven core elements, **required** by the OIG.

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**.
8. Bonus Element: **Non-Retaliation**

FRAUD, WASTE & ABUSE COMPLIANCE TRAINING

THE COMPLIANCE TEAM IS ALWAYS AVAILABLE:

PHONE: ACTION LINE AT 1.866.293.3863

OR COMPLIANCE DEPARTMENT AT 502.630.7023

EMAIL: COMPLIANCETEAM@BRIGHTSPRINGHEALTH.COM

WEB FORM: [HTTPS://WWW.BRIGHTSPRINGHEALTH.COM/CONTACT-US/](https://www.brightspringhealth.com/contact-us/)

QR CODE:



ELEMENT 5: DISCIPLINARY POLICIES

- Employees who 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 to violators at all levels of the organization.
- Corrective action/discipline should be proportional to the offense/infraction.
- HR Policy and procedure details & provides guidance related to corrective action.
- All allegations and reports will be promptly and thoroughly investigated.

ELEMENT 6: AUDITING & 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, action is taken to prevent future issues.

ELEMENT 7: RESPONDING TO COMPLIANCE ISSUES

- All FWA allegations and other compliance concerns reported to the compliance department will be logged, and promptly and 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.

FRAUD, WASTE & ABUSE COMPLIANCE TRAINING

NON-RETALIATION:

- Employees who bring forth their good faith concerns to the Compliance Department are protected from retaliation, retribution, and intimidation.
- Maliciously false accusations and repeated misuse of the Action Line will be addressed through corrective action.
- All affected individuals (BrightSpring Health Services and PharMerica and its pharmacy subsidiaries), board members and executives, all employees, contractors, agents, and 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: 1.502.630.7023
 - Compliance Action Line: 1.866.293.3863
 - Email: complianceteam@brightspringhealth.com

NYS SPECIFIC INFORMATION

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:

- 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,
- Cooperating with or participating in the investigation of such,
- Assisting with or participating in self-evaluations, audits and/or implementation of remedial actions, and/or
- 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 740 and 741).

Reporting to our Hotline can be anonymous and confidential 24/7 at 1.866.293.3863, 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
- NYS OMIG, 800 North Pearl St., Albany, NY 12204 www.omig.ny.gov
- HHS and US DOJ at <https://www.stopmedicarefraud.gov> or or 1.800.447.8477 or TTY 1.800.377.4950.

BrightSpring / PharMerica 24/7 Compliance Action Line 1.866.293.3863

FRAUD, WASTE & ABUSE COMPLIANCE TRAINING

NYS SELF-DISCLOSURE PROGRAMS

- Provider will comply with the requirements of SubPart 521-3 (Self-Disclosure Programs) to report, return, and explain overpayments
- This would be done through the OMIG Self-Disclosure Program
- Corrective Action Plans will be put in place for all audits and investigations
- <https://omig.ny.gov/provider-resources/self-disclosure>
- Self-Disclosure email: selfdisclosures@omig.ny.gov

SUMMARY

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

BRIGHTSPRING HEALTH SERVICES COMPLIANCE CONTACT INFORMATION

PHONE: ACTION LINE AT 1.866.293.3863
OR COMPLIANCE DEPARTMENT AT 502.630.7023

EMAIL: COMPLIANCETEAM@BRIGHTSPRINGHEALTH.COM **OR**
DG:COMPLIANCETEAM@PHARMERICA.COM

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