Pathways, Inc.

we put people first

Corporate Compliance Program

Policy & Procedure Manual

Board of Directors Approval – January 21, 2014, Revised and approved 12/20/20, Revised February / March 2023, approved March 21, 2023

President & Chief Executive Officer
Joseph M. Cevette, MPS

Pathways, Inc.
Corporate Compliance Program
Policy & Procedure Manual

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Pathways Inc.

Corporate Compliance Program

Pathways, Inc. Corporate Compliance Program Plan

Policy Purpose

The purposes of the Compliance Program are:

1. It is the purpose of such compliance programs to detect and prevent fraud, waste, and abuse in the Medicaid program as well as organize provider resources to address compliance issues as quickly and efficiently as possible, and to impose systemic checks and balances to prevent future recurrence of such issues.

2. To promote and ensure high standards of care and service for the people with whom we interact and to conduct business in a manner that supports integrity in it's operations.

3. To educate Board members, directors, employees and affiliate professionals of Pathways, Inc. concerning the legal and financial risks of certain business practices.

4. To encourage Pathways, Inc. managers and employees to seek appropriate counsel regarding business practices, and to conduct those activities within the requirements of the law and ethical standards of conduct for Pathways, Inc. employees.

5. To secure compliance with all applicable laws, regulations, payer requirements and professional, and ethical standards for quality care.

In furtherance of Pathways, Inc.'s Mission, Vision, Philosophy and Values management will exercise best practices to prevent and detect unlawful and/or unethical conduct by its employees and agents. Pathways, Inc. is committed to excellence and a zero tolerance environment.

Policy Scope 521-1.1(b) – SS 363-d

Definitions Section § 521-1.2(a) incorporates the definitions from 18 NYCRR Part 515, which includes definitions for the terms "fraud" and "abuse." "Abuse" is defined in 18 NYCRR § 515.1(b)(3), and "fraud" is defined in 18 NYCRR 515.1(b)(7). Although not defined in regulation, waste generally is defined as "the overutilization of services, or other practices that directly or indirectly, result in unnecessary cost to the Medicaid program." Category or categories of service related to the definition of "organizational experience" refers to the category(ies) of service in which Pathways, Inc. is enrolled in the Medicaid program.

Providers subject to these requirements consist of enrolled New York State Medicaid program providers who are categorized as hospitals, residential health care facilities, home care services agencies, providers of developmental disability services, providers of mental disability services, managed care plans, and managed long-term care plans, regardless of the amount claimed or received from the Medicaid program. Beyond these service categories, the definition also includes any enrolled provider

that claims or receives $1 million or more directly or indirectly (such as managed care network participating providers) from the Medicaid program.

Pathways, Inc. is committed to establishing and observing high standards and ethical conduct in its business and operational practices. This policy establishes a corporate compliance program and policies and procedures that conform to the standards set forth in the federal and state statutes, rules, regulations, and Medicaid program requirements. The Compliance Program shall be a Pathways, Inc. agency-wide program structured to encourage collaborative participation at all levels of the Agency. The Compliance Program shall focus on the detection and prevention of violations of federal, state and local laws and payer requirements. The Compliance Program shall foster an environment in which employees and affiliated professionals comply with all relevant laws and regulations, and report any concerns about business practices as set forth under this policy.

Policy Procedures

1. **Compliance Program Positions**

   A. **Corporate Compliance Officer**

   The Pathways, Inc. Corporate Compliance Officer shall be a designee who is delegated authority for day-to-day operation of the Compliance Program. The Corporate Compliance Officer shall report directly to the President & CEO of Pathways, Inc., and shall have a reporting relationship to the Chief Operating Officer and respective Vice Presidents of Operations. The Corporate Compliance Officer shall also have direct access to the Board if required.

   Pathways, Inc. will demonstrate whether the other duties of the compliance officer are a hindrance to carrying out their primary responsibilities, and whether the compliance officer is able to satisfactorily perform their responsibilities. Such assessment should be completed during the annual compliance program effectiveness review (as required in element 6), or whenever the compliance officer's duties change.

   Pathways, Inc. will demonstrate whether the compliance officer is allocated sufficient staff and resources to satisfactorily perform their responsibilities for the day to-day operation of the compliance program. Such assessment should be completed during the annual compliance program effectiveness review (as required in element 6).

   B. **President & CEO**

   The Pathways, Inc. President & CEO and Compliance Officer shall be accountable to the Board of Directors for the implementation and on-going operations of the Compliance Program. The Board of Directors shall receive reports at least quarterly on the status and effectiveness of the Compliance Program.

C. **Corporate Compliance Committee**

A Corporate Compliance Committee shall be created and will consist of members of senior management and the Board from across the Agency. This Committee will have the responsibility of assisting the Compliance Officer in the implementation of the Compliance Program. The Committee shall provide guidance, support and feedback for the development and implementation of priorities for the Compliance Program. In addition, the Committee shall establish priorities for educational programs to be provided as part of the Compliance Program and to help identify necessary human and financial resources required for the effective implementation of the Compliance Program.

D. The Pathways, Inc. Quality Assurance Department shall work with the Corporate Compliance Officer in auditing and monitoring compliance throughout Pathways, Inc. On an ongoing basis the Pathways, Inc. Quality Assurance Department shall assist the Corporate Compliance Officer with preparing reports and the results of the compliance initiatives and employees adherence to the Compliance Program for the Corporate Compliance Committee.

2. **Element of the Compliance Program**

A. **Corporate Compliance Officer**

The Corporate Compliance Officer will be responsible for the development, operation and oversight of the Compliance Program.

B. **Employee Code of Conduct**

Pathways, Inc. shall establish a Code of Conduct, which shall govern the proper conduct of Pathways, Inc. employees and Board of Directors and shall require Directors, officers, employees and affiliated professionals to comply with the ethical and legal standards outlined in this Compliance Program.

C. **Compliance Standards**

The Compliance Program will establish written standards, including policies and procedures, in order to assure legal and ethical compliance.

1) The Corporate Compliance Officer, in collaboration with members of the Corporate Compliance Committee and Quality Assurance Department, shall develop a process to identify those areas where there is a potential substantial risk that certain types of unlawful/unethical conduct may occur.

2) The Corporate Compliance Officer shall ensure the development of Compliance Standards for each applicable program; and policies shall be developed through the respective Vice President assigned to focus on identified risk areas, to develop standards, and to formulate appropriate policies and procedures for compliance with ethical and legal standards.

3) The Compliance Standards shall require promotion of, and adherence to, compliance as an element of evaluation performance of managers at Pathways, Inc. facilities and programs.

D. **Evaluation of Business Practices**

In order to evaluate Pathways, Inc. business practices, the Corporate Compliance Officer shall:

1) In coordination with Pathways, Inc. management, ensure that Pathways, Inc. business practices are monitored to ensure compliance with Pathways, Inc. policies and procedures and Compliance Program.

2) Ensure consistency in the application of Pathways, Inc. policies and procedures with the requirements of the Compliance Program and implement appropriate corrective action.

3) Ensure that reasonable steps are taken to respond appropriately to ethics and/or legal compliance violations, to prevent further similar violations, and to recommend appropriate and consistent discipline for violators.

4) Oversee, as appropriate, investigations of ethics and/or legal Compliance Policy violations to ensure consistency in the enforcement of Pathways, Inc. policies.

E. **Effective Reporting and Investigative Processes**

Under the general direction of the Corporate Compliance Officer and guidance from the Corporate Compliance Committee, Pathways, Inc. shall implement processes to provide education and guidance on Pathways, Inc. ethics and legal compliance policies and procedures, and for the reporting and investigation of business issues.

1) Each employee shall have the responsibility to notify their supervisor, in a timely manner, of any violations or suspected violations of the standards for ethics and legal conduct. In the alternative, an employee may follow the reporting procedure under section E(2) hereof. Employees will be informed that in some instances, the mere failure to report a suspected violation may itself be a basis for disciplinary action against an employee.

2) A written procedure is available, compliance email and a confidential telephone line (607-937-3280) is available to employees and others who may wish advice on certain policies and procedures, or who wish to report possible violations of law applicable to Pathways, Inc. policies and procedures and payer requirements.

3) Employees will not be subject to reprisal for reporting, in good faith, actions that they feel violate the law or established standards. Any employee engaging in any act of reprisal for any good faith reporting shall be subject to discipline and/or discharge.

F. **Effective Communication and Training Programs to Alert Employees of Their Responsibilities**

The Corporate Compliance Officer, with the guidance of the Corporate Compliance Committee, shall have general responsibility to oversee the development and implementation of employee communications and training programs to ensure compliance with the Compliance Program. The communication and training programs shall include the following areas:

1) New employee orientation (to include coverage of ethics and legal compliance issues).

2) Department specific training and education programs in identified high risk areas.

3) Annual review of ethics and legal compliance issues in departments at substantial risk and specific business practices. Compliance refresher training shall occur annually for employees and Board members.

4) The identification of resources to provide effective compliance educational programs.

5) Those who receive training shall be informed that strict compliance with both the Pathways, Inc. Code of Conduct and the requirements of the Compliance Plan is a condition of employment or other association with the Agency.
   a) The promotion of, and adherence to, compliance with the Code of Conduct and the requirements of the Compliance Plan are elements of evaluating supervisors and managers.
   b) Pathways, Inc. will address the non-employment or retention of employees who are sanctioned for a violation of either the Code of Conduct or the requirements of the Compliance Plan.

G. **Monitoring Compliance with Compliance Policy**

1) The Compliance Program shall include monitoring and auditing systems designed to detect ethical or legal violations, and a reporting system whereby employees may report suspected violations of standards for ethical and legal conduct.

2) Quality Assurance staff shall, in consultation and collaboration with the Corporate Compliance Officer and Corporate Compliance Committee, coordinate appropriate internal audits and surveys to verify adherence to, and awareness of, Pathways, Inc. ethics and compliance policy and procedures.

3) Quality Assurance shall:
   a) Identify audits required to verify adherence to, and awareness of, ethics and compliance policies throughout Pathways, Inc.
   b) Review the results of periodic surveys to test awareness of Pathways, Inc. ethics and legal compliance policies and procedures.

c) Conduct special audits as necessary to verify adherence to Pathways, Inc. ethics and compliance policies and procedures. These audits may include:

1. On-site visits
2. Interviews with personnel
3. Reviews of written materials and documentation
4. Trend analysis studies
5. Compliance Related Investigations

H. **Keeping Pathways, Inc. Informed Concerning Compliance with Ethical and Legal Standards**

The Corporate Compliance Officer shall:

1) Report to the President & CEO regarding the Compliance Program on an on-going basis.

2) Provide information to the Board of Directors at least quarterly via Compliance Committee meeting minutes and discussion

3) Report to the Corporate Compliance Committee regarding the Compliance Program on a quarterly basis.

PATHWAYS, INC. Corporate Compliance Manual	DATE ISSUED 1/1/02	DATE REVIEWED/ REVISED 3/21/23	PAGE 1 of 3	TOPIC NO. 1 CCP
POLICIES AND PROCEDURES MANUAL	FUNCTION: Corporate Compliance Program			
SOURCE/REFERENCE 18 **NYCRR Part 521** **521-1.4**	SUBJECT: Written Policies & Procedures Policy and Procedure Development and Implementation			
	TOPIC: Pathways, Inc. Compliance Committee & Board of Directors			

Seven Elements of Compliance
Title 18 NYCRR Part 521

Element #1
Pathways, Inc.'s obligations related to compliance program requirements should be incorporated into Pathways, Inc.'s written policies, procedures, and standards of conduct (Policies). The written Policies should outline the operation of the compliance program and be reviewed at least annually and modified, as necessary. Pathways, Inc.'s written Policies regarding of service. Referencing the governing laws, regulations, and Medicaid program policies and procedures applicable to Pathways, Inc.'s risk areas and/or categories of service, by citation in the written Policies, would be appropriate and sufficient to meet the requirements of this element. The only exception is written policies and procedures related to 42 U.S.C. 1396a(a)(68), which require detailed information.

POLICY

Evidence that written Policies were in effect includes, but is not limited to, the following:

1. A detailed set of compliance written Policies that include a record of implementation and revision dates for individual Policies.

2. Evidence that the written Policies were applicable to all affected individuals. "Affected Individuals" is defined as all persons who are affected by Pathways, Inc.'s risk areas, including employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors, and governing body and corporate officers.

3. Documentation of an annual review of written Policies and any identified updates as noted in Compliance work plan and identified in Compliance Committee meeting minutes.

4. Evidence that written Policies were distributed to all Affected Individuals.

5. There is work product that demonstrates the written Policies were in effect or operating. For example: training and work plans existed, evidence that investigations were commenced and completed, and actions were taken in response.

6. A demonstration that Pathways, Inc. met the Deficit Reduction Act (DRA) requirements by submitting written Policies and any employee handbook that specifically addressed all DRA requirements. If Pathways, Inc. did not have an employee handbook, they do not need to establish one. However, if Pathways, Inc. did have an employee handbook, it should meet the requirement

PROCEDURE

Policy Development

1. Pathways, Inc. Compliance Committee and Compliance Officer will determine if areas of potential compliance risk exist within an Agency or Department function.

2. If it is determined that a compliance risk exist, and there is no existing policy and procedure that addresses the issues in question, a policy and procedure will be developed that addresses this risk as it pertains to the Pathways, Inc. Compliance Program.

3. The Compliance Officer will collaborate with relevant staff, when developing policy and procedures that address issues of compliance risk within a specific site.

4. All policies and procedures will be developed utilizing a standard format, and be incorporated into the Pathways, Inc. Corporate Compliance Program Policy and Procedures manual.

5. Once developed, a policy and procedure will be distributed by the Compliance Officer to all members of the Pathways, Inc. Compliance Committee prior to the next scheduled meeting for their review.

6. The policy and procedure will be presented at the Committee meeting. If no further revisions are indicated, the committee will provide approval, forward to the Pathways, Inc. Board of Directors for final approval and authorize implementation/distribution of the policy and procedure. If modifications are requested, the Compliance Officer will make the necessary changes and resubmit the document to the Committee for reevaluation. Upon committee approval the document will then be forwarded to the Pathways, Inc. Board of Directors for final approval or to recommend it for resubmission to the committee.

7. The date of issue for a Policy and Procedure will be the date of final Board of Directors approval.

8. If revisions to an existing policy and procedure are needed, follow steps 5-6 for approval purposes and indicate on the policy and procedure the date it was revised. If replacing an existing policy, ensure that the replaced policy is retired. Retired policy will be archived per agency archiving process.

9. Upon approval of new and revised policy and procedures the Compliance Officer will disseminate to all sites utilizing the ADP web site and Shared Drive. Upon the dissemination of new and revised policy and procedures appropriate education and training will be conducted.

10. All employees will be given a copy of the Code of conduct annually associated with the Compliance Program; in addition, all policy and procedure documents associated with the Compliance Program will be either kept in ADP (resources tab) accessible to all employees or otherwise made available for inspection by all employees.

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POLICIES AND PROCEDURES MANUAL	FUNCTION: Corporate Compliance Program			
SOURCE/REFERENCE 18 **NYCRR Part 521** 18 **NYCRR Part 521** **521-1.4(b)** **521-1.4(c)**	SUBJECT: Compliance Officer & Compliance Committee			
	TOPIC: Pathways, Inc. Compliance Committee & Board of Directors			

Seven Elements of Compliance
Title 18 NYCRR Part 521

ELEMENT #2:

Compliance Officer and Compliance Committee will demonstrate their compliance program is well-integrated into the company's operations and supported by the highest levels of the organization by ensuring there is a designated compliance officer who is vested with responsibility for the day-to-day activities of the compliance program.

POLICY
The Pathways, Inc. Compliance Officer is delegated authority for the day-to-day operation of the Pathways, Inc. Corporate Compliance Program. The Compliance Officer shall report directly to the President & CEO of Pathways Inc., and shall have a reporting relationship to the Chief Operating Officer and respective Executive Vice President. Each program/site Manager will be responsible for the implementation and adherence to the Compliance Program at the specific program/site.

PROCEDURE

1. The Compliance Officer is accountable to the Chief Executive Officer and has access to the governing board. The Compliance Officer will ensure the development, operation and oversight of the Compliance Program.
2. The Compliance Officer shall ensure the development of Compliance Standards for each applicable program. The Compliance officer will develop appropriate policy and procedures for compliance with ethical and legal standards, and submit them to the Compliance Committee for approval, and Board of Directors for final approval.
3. In order to evaluate Pathways, Inc. business practices, the Compliance Officer shall:
    - In coordination with Pathways, Inc. Management, ensure that Pathways, Inc. business practices are monitored to ensure compliance with Pathways, Inc. policies and procedures and Compliance Program.

    - Ensure consistency in the application of Pathways, Inc. policies and procedures with the requirements of the Compliance Program, and implement appropriate corrective action.

- Ensure that reasonable steps are taken to respond appropriately to ethics and/or legal compliance violations, to prevent further similar violations, and to recommend appropriate and consistent discipline for violators.
- Oversee, as appropriate, investigations of ethics and/or legal Compliance Program violations to ensure the consistency in the enforcement of Pathways, Inc. policies and procedures.
- The Compliance Officer will report to the President & CEO regarding the Compliance Program on an on-going basis.

4. The Compliance Officer will oversee and implement the agency Compliance Program and compliance with the requirements of Federal health care programs, State Medicaid programs and other payer requirements. The Compliance Officer's responsibilities for implementation and oversight of the Compliance Program include, but are not limited:

a) Develop and implement policies and procedures.
b) Develop, implement and oversee the Agencies Corporate Compliance Program.
c) Develop and oversee an annual internal auditing schedule to monitor effectiveness of the compliance programs standards.
d) Develop, coordinate and or implement compliance education for all employees.
e) Coordinate internal investigations and implement corrective actions.
f) Coordinate ethical and compliance related investigations and report directly to the President & CEO and the Board of Directors.
g) Maintain a reporting system to track and respond to agency personnel and service recipient concerns, complaints and questions related to the corporate compliance program.
h) Maintains a dedicated compliance email account & confidential hotline and ensures all agency personnel and service recipients are informed of the confidential communication system.
i) Ensure no intimidation or retaliation for good faith reporting,
j) Act as Chairperson of the Compliance Committee. Organizes membership of the committee and facilitates a quarterly Compliance Committee meeting. Reports all compliance activities directly to the Board of Directors (BOD) routinely BOD meetings.

5. The Compliance Committee reports directly to the Chief Executive Officer and governing board.
6. The Compliance Committee will enact a charter that includes duties and responsibilities for coordinating with the compliance officer.

7. The Pathways, Inc. Compliance Committee membership will have Board of Director representation and consist of senior management from across the Agency. The Committee will provide guidance, support, and oversight of the implementation and day-to-day operations of the Compliance Program. The Committee will meet quarterly, and the Compliance Officer will report the activities of the Compliance Program to the committee at this time.
8. The Program Manager, Director and respective EVP of each site will act as a liaison between the program/site and Compliance Officer for training, monitoring/auditing, investigation, and corrective action purposes.

Duties of the Compliance Committee include but are not limited to;

a) Continually monitor existing policy and procedures to ensure adherence to identified compliance standards.
b) Provide guidance, support and oversight for the implementation and day-to-day operation of the Compliance Program.
c) Monitor the environment with regards to applicable laws, policy, regulations or procedures which the Agency must operate under.
d) Monitor all auditing conducted on the Agency to identify and address risk areas. Assist in the development of Plans of Corrective Action.
e) Monitor each program's Plan of Corrective Actions to ensure adherence to the Compliance Standards.
f) Review and or make recommendations in response to all compliance investigations, identified trends or identified risk areas
g) Assist the Compliance Officer in the development of compliance education for all employees
h) Review all OMIG and OIG compliance communications to ensure policy and procedure exists within the Pathways Compliance program.
i) Annually review and revise the compliance committee charter.
j) Assist the compliance officer in developing reports to the chief executive and governing board. (Monthly reports are prepared for the Governing Board.)
k) Routinely monitors Exclusion Status of all Affected Individuals.
l) The Compliance Committee will be responsible for reviewing and approving all Compliance Program policies and procedures, and forwarding them to the Pathways, Inc. Board of Directors for final approval before they are implemented.

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<tr><td>POLICIES AND PROCEDURES
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18 NYCRR Part 521
521-1.4(b)
521-1.4(c)</td><td colspan="4">SUBJECT:
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& Board of Directors</td></tr>
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By Title the Compliance Committee shall consist of the following;

- Executive Vice President
- Chief Financial Officer
- Member of the Board of Directors
- Executive Vice President of Quality Assurance (Compliance Officer)

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POLICIES AND PROCEDURES MANUAL	FUNCTION: Corporate Compliance Program			
SOURCE/REFERENCE 18 **NYCRR Part 521** 18 NYCRR § 521-1.4(d)	SUBJECT: Compliance Training			
	TOPIC: Pathways, Inc. Compliance Committee & Board of Directors			

Seven Elements of Compliance
Title 18 NYCRR Part 521

ELEMENT 3:

Compliance Program Training and Education

Pathways, Inc. will demonstrate they have established and implemented an effective compliance training and education program for all Affected Individuals. Compliance training and education must be documented in an annual training plan that is maintained and outlines: required subjects or topics, timing and frequency of training, which affected individuals are required to attend, how attendance is tracked, and how the effectiveness of the training is periodically evaluated

POLICY

The proper education and training of all affected individuals including members of the Board of Directors, Administrators, Managers, Employees, contractors and the continual retraining of current personnel at all levels, are significant elements of an effective Compliance Program. At Pathways, Inc., in order to ensure the appropriate information is being disseminated to the correct individuals, the Compliance Training Program will be separated into two sessions. All Pathways, Inc. Employees will attend a general session on the Compliance Program (orientation), while program/site representatives will receive comprehensive annual refresher program. Additionally, contractors will receive refresher training upon renewal of each contract. Retraining and updates on compliance issues will occur ongoing or as requested or identified by the Compliance Officer or the Compliance Committee. Adherence to the Pathways, Inc. Compliance Program is a condition of employment. Pathways Inc. established and implemented effective training and education for its compliance officer and organization employees, the chief executive and other senior administrators, managers and governing body members.

Only distributing the written policies does not qualify as effective compliance training and education. Self-study programs are acceptable where written Policies and/or compliance training materials are distributed, so long as Pathways, Inc. can produce evidence that individuals being trained have received and appropriately applied the subject matter.
Contractors can be treated the same as other types of Affected Individuals for self-study compliance

training programs. It is a best practice to include a dated distribution letter or have Contractors complete an acknowledgement to evidence that compliance training materials were provided.

PROCEDURE

1. All new employees will receive a Compliance Program overview during Agency Orientation, which occurs within the first three months of hire. This overview will entail discussion of the Pathways, Inc. Code of Conduct, and include a post session evaluation to determine employee understanding. Employees must demonstrate 100% competency in this area. Each employee will be required to sign an acknowledgment form indicating receipt of the Code of Conduct and completion of the overview. This document will be retained in the employees personnel file. The Human Resources Department will be responsible for conducting this overview and will be completed annually.

2. Annually, affected individuals will be scheduled for an annual compliance refresher to be conducted by the Compliance Officer or designee. The annual refresher will consist of policy review, any identified compliance trends both specific to the program and systemically (Organizational Experience) and a review of the Code of Conduct. A compliance competency test will be issued immediately following each refresher training to be corrected by the Compliance Officer or designee to identify possible staff related compliance concerns. Programs not funded by Medicaid will undergo an annual refresher conducted by the Manager / designee of each site identifying the Code of Conduct.

3. In the event that staff are not in attendance at the annual refresher, a self-study packet and exam will be issued by the Manager / Director. Once complete, the exam will be forwarded to the Compliance Officer for correction and then to the training department for record keeping. Monthly the training department will forward a list of all employees not in compliance to the Compliance Officer for follow up and training completion.
4. As the result of Compliance Investigations, identified trends or per request, additional compliance training may be warranted.

5. Employees who are responsible for record keeping and billing procedures must demonstrate 100% competency in this area. Retraining and updates will be provided periodically and as indicated by program/site risk.

6. Board members newly assigned to the Pathways, Inc. Board of Directors will receive Compliance training with in the first three months of joining the BOD. Annually thereafter all Board members will receive compliance refresher training.

7. Contractors, as new affected individuals join Pathways Inc., the initial contract and contract renewals will include signing off on compliance related training materials indicating their understanding of compliance expectations. Contracts will include termination clauses for noncompliance.

8. Pathways, Inc. affected individuals include agency personnel contributing to the Medicaid program, Senior Management, Board of Directors and contractors.

9. All trainings will be conducted by Compliance Officer or designee. All compliance training attendance will be forwarded to Pathways, Inc. training department.

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POLICIES AND PROCEDURES MANUAL	FUNCTION: Corporate Compliance Program			
SOURCE/REFERENCE 18 **NYCRR Part 521** 521-1.4(e)]	SUBJECT: Lines of Communication			
	TOPIC: Pathways, Inc. Compliance Committee & Board of Directors			

Seven Elements of Compliance
Title 18 NYCRR Part 521

- Confidential Hot Line
- Compliance Email
- Compliance Lines to the Compliance
- Officer
- Reporting Violations
- Non Intimidation / Non Retaliation
- Qui Tam Provisions

ELEMENT 4:

Lines of Communication- Providers should demonstrate that they have established and implemented effective lines of communication for all Affected Individuals. These lines of communication must guarantee the confidentiality of reporting persons. "Lines of communication" is interpreted very broadly to include telephone, email, website-based correspondence, interoffice mail, regular mail, face-to-face interaction, drop box, and any other reasonable means to communicate. Anonymous methods of communication should be truly anonymous so reporting persons have assurance that there is no way the compliance function can discover who is reporting a matter.

POLICY

All employees have the responsibility to comply with applicable laws and regulations and to report concerns about any real or potential non-compliance with applicable federal, state and local laws and internal policies and procedures. Pathways, Inc. is firmly committed to a policy, which encourages timely disclosure of such concerns and prohibits retribution or retaliation against anyone who in good faith reports such concerns. This policy is intended to protect any individual who engages in good faith disclosure of alleged non-compliance to a designated Pathways, Inc. official. All employees are required to report acts of non-compliance, including any suspected violations of law, professional and ethical standards, or company policies. Any suspected incidents of non-compliance shall be reported to the Compliance Officer who may in turn confer with legal counsel to ascertain the most appropriate means of investigating and responding to such report. Compliance personnel and/or legal counsel shall conduct investigations in a timely manner.

Any employee found to have known of such acts but who failed to report them may be subject to disciplinary action. The Agency will do their best to maintain the reporting sources confidentiality.

PROCEDURE

1. Any illegal, unethical or improper activities need to be reported, investigated and rectified. As a guideline, either notify your manager, the Compliance Officer, compliance email or call the confidential Compliance Line at 607-937-3280 if you know of or suspect any violations of the following:
    - Medicaid reimbursement regulations
    - Inaccurate billing
    - Internal accounting controls
    - Breach of Individual confidentiality
    - Criminal activity (fraud/fiscal abuse)
    - Individual rights
    - Program regulations
    - Policies & Procedures
    - Compliance Plan Policy and Procedures
    - Any act of retribution or retaliation for good faith reporting
    - Any HIPAA related violations

PROCEDURE

1. If an employee does not feel comfortable reporting to a manager/director, they can email the compliance email box at Compliance660@pathwaysforyou.org or contact the Compliance Officer directly at 607-937-4557, or if an employee wishes to report their concerns anonymously & confidentially or after hours they can utilize the confidential Compliance Line 24 hours a day, seven days a week, at 607-937-3280. All reporters will remain confidential unless the matter is subject to a disciplinary proceeding, referred to, or under investigation by, MFCU, OMIG or law enforcement, or disclosure is required during a legal proceeding, and such persons shall be protected under the required provider's policy for non-intimidation and non-retaliation.
2. Any employee who perceives or learns of an act of non-compliance should: speak to his/her Manager, call the Compliance Officer, email the compliance email box or call the confidential Compliance Line at 607-937-3280.

3. Managers are required to report these issues directly to the Compliance Officer upon discovery or
4. directly to the President & CEO if the Compliance Officer is involved.
5. For general compliance questions, email the compliance mailbox, email the compliance officer or quality assurance staff or call the compliance officer and/or quality assurance staff.
6. If an employee does not feel comfortable reporting to a manager, they can contact the Compliance Officer directly at 607-937-4557.
7. If an employee does not wish to speak directly to the Compliance Officer or needs to make a report after hours they can utilize the confidential Compliance Line 24 hours a day seven days a week at 607-937-3280. This is a voice mailbox that is directly accessed by the Compliance Officer. When calling this number employees will be asked to provide the following information:
    a. Name or location of the site
    b. Date of the call
    c. Any relevant information concerning the allegations
    d. Name of the caller and contact phone number for the caller (optional)
    e. A brief description of the concern.

All employees are encouraged to call the Compliance Officer directly or Compliance Line if they have any questions about whether their concern should be reported. Confidentiality of the caller will be maintained.

Timely reporting allows Pathways, Inc. the opportunity to thoroughly investigate and take action to resolve any suspected compliance concerns so that they may be properly resolved. All reports of suspected violations will be acted upon immediately by the Compliance Officer or designee. All investigations will prompt notification to the Compliance Committee and the Pathways, Inc. Board of Directors.

Personal Obligation to Report

We are committed to ethical and legal conduct that is compliant with all relevant laws and regulations and to correcting wrongdoing wherever it may occur in the organization. Each colleague has an individual responsibility for reporting to the Compliance Officer any activity by any affected person that appears to violate applicable laws, rules, regulations, or this Code.

Pathways, Inc. is committed to establishing and observing high standards and ethical conduct in its business and operational practices. This policy is intended to create an open and honest atmosphere and

to ensure employees have an opportunity to report in good faith any wrong- doing without fear of intimidation or retaliation for having made the report.

A "Good Faith Report" is a report made in the absence of malice or any intention to deceive".

Qui Tam Provisions

The federal and state false claims act encourages individuals to report misconduct through the qui tam provisions. A claim under the Federal False Claims Act is filed on behalf of the United States, and often referred to as a "qui tam" action. A qui tam suit is a suit brought by an individual on behalf of the United States government seeking to expose and thereby stop the wasting of federal funds. The qui tam relator, often referred to as a whistleblower, if successful in his or her suit, is entitled to a percentage of the funds recouped by the federal government.

The False Claims Act prohibits discrimination against any employee for taking lawful actions under the False Claims Act. Any employee who is discharged, demoted, harassed, or otherwise discriminated against because of lawful acts by the employee in False Claims actions is entitled to relief.
The agency has a procedure for reporting compliance concerns and strictly prohibits retaliation against an employee who raises a compliance concern in good faith.

PATHWAYS, INC. Corporate Compliance Manual	DATE ISSUED 1/1/02	DATE REVIEWED/ REVISED 3/21/23	PAGE 1 of 2	TOPIC NO. 5 CCP
POLICIES AND PROCEDURES MANUAL	FUNCTION: Corporate Compliance Program			
SOURCE/REFERENCE 18 **NYCRR Part 521** 521-1.4(f)	SUBJECT: Disciplinary Standards			
	TOPIC: Pathways, Inc. Compliance Committee & Board of Directors			

Seven Elements of Compliance
Title 18 NYCRR Part 521

ELEMENT 5:
Disciplinary Standards. Pathways, Inc. will demonstrate they have established disciplinary standards as per agency policy and procedure and have implemented procedures for the enforcement of such standards to address potential violations and encourage goodfaith participation in the compliance program by all Affected Individuals.

Disciplinary standards that encourage good faith reporting include the following;
1. Expectations for reporting compliance issues.
2. Expectations for assisting in the investigation and resolution of compliance issues.
3. Sanctions for failing to report suspected problems.
4. Sanctions for participating in non-compliant behavior.
5. Sanctions for encouraging, directing, facilitating, or permitting non-compliance behavior.

Procedure

1. At the first indication of non-compliance the program/site manager/supervisor will discuss the non-compliance with the affected individual(s) and advise them of what is expected of them and how they can correct the deficiency. The date and nature of the discussion should be noted and documented by the manager/supervisor and forwarded to the Compliance Officer.

2. If continued non-compliance or additional problems are identified the next step would be a formal written warning. This warning will be documented utilizing the formal Counseling Report Form, and will be filed in the affected employee(s) personnel file. This document will highlight the area of non-compliance and identify employee expectations and a plan of action for correcting the areas of non-compliance. The formal counseling report will be copied in to the Compliance Officer for review.

3. When circumstances indicate that there is continued or serious acts of non-compliance, suspensions (without pay or payment) may occur. If a suspension occurs the manager/supervisor or designee is required to complete a Notice of Disciplinary Action Form and should inform the Compliance Officer and Executive Vice President of Human Resources. A suspension is an indication of a severe deficiency and may jeopardize the employee's continued employment.

4. After progression through the previous steps and /or a severe act of non-compliance, termination may occur. All cases that reach this step must be reviewed and approved by the Chief Human Recourses Officer, respective Executive Vice President and the President & CEO or designee.

5. Depending on the severity and circumstances of the non-compliance, management has the discretion to circumvent any steps within this progressive discipline policy.

6. As appropriate, a compliance investigation may be initiated to ensure the integrity of the program documentation and or compliance standards.

7. Sanctions and or disciplinary action will include all affected individuals including employees, non-employees (vendors, contractors, Board of Directors) that may be involved in any non-compliant behavior, consistent with contracts, by-laws and other relevant documents.

PATHWAYS, INC. Corporate Compliance Manual	DATE ISSUED 1/1/02	DATE REVIEWED/ REVISED 3/21/23	PAGE 1 of 3	TOPIC NO. 6 CCP
POLICIES AND PROCEDURES MANUAL	FUNCTION: Corporate Compliance Program			
SOURCE/REFERENCE 18 **NYCRR Part 521** 521-1.4(g)	SUBJECT: Auditing & Monitoring			
	TOPIC: Pathways, Inc. Compliance Committee & Board of Directors			

ELEMENT 6:

Auditing and Monitoring Providers should demonstrate that their compliance program includes routine auditing and monitoring of compliance risks. This may include, but is not limited to, the following: 1. Internal and external audits are documented and shared with the compliance committee and governing body. 2. The annual compliance program reviews are shared with the chief executive, senior management, compliance committee, and governing body. 3. Monthly exclusion checks are shared with the compliance officer and appropriate compliance personnel.

POLICY

Monitoring of compliance with applicable laws and regulations is a central feature of the Pathways, Inc. Compliance Program. The Compliance Officer must be able to ensure compliance through an understanding of current regulations and overall levels of compliance throughout the Agency at any given time. The Compliance Officer, in collaboration with the Compliance Committee and Quality Assurance Department, will be responsible for monitoring individual sites and affected individuals' compliance with applicable laws and regulations. The Compliance Officer will ensure that the level of compliance in each site is audited periodically. The Compliance Officer, in consultation with the President & CEO, may elect to retain counsel to direct or advise as to any audits or investigations conducted in the interests of compliance. These audits or investigations may include (a) on-site visits, (b) interviews with personnel, (c) reviews of written materials and documentation, and (d) trend analysis studies. The Compliance Officer will communicate the results of the review to the individual sites, the Compliance Committee, and Board of Directors as required. If the Compliance Officer discovers that a site or individual's level of compliance is unacceptable, the Compliance Officer shall ensure that a plan of corrective action is implemented. Corrective action and sanctions for acts of non-compliance will be enacted.

PROCEDURE

1. Pathways, Inc. will conduct internal compliance audits that will focus on required risk areas.

2. Any identified Medicaid program overpayments are reported, returned, and explained in accordance with Medicaid self-disclosure program requirements.

3. Pathways, Inc. will conduct annual reviews of the compliance program to determine its effectiveness, and whether any revision or corrective action is required.

4. Pathways Inc. will verify the exclusion status of all affected individuals by contracting with Kinney Management Services to conduct reviews every thirty days.
MMCOs shall confirm the identity and determine the exclusion status of any other persons identified in its contract with the department to participate as an MMCO, including its participating providers and its subcontractors. In addition, MMCOs shall require their participating providers and subcontractors, where applicable, to confirm the identity and determine the exclusion status of all affected individuals. Providers shall complete an annual review of whether the Medicaid compliance program requirements have been met, to determine the effectiveness of its compliance program, and whether any revision or corrective action is required. Completing an annual review is an essential component of an effective compliance program and helps providers prepare for their annual certification and an OMIG compliance program review

Schedule

1. The Quality Assurance Department will schedule periodic record reviews with individual programs/sites at least two weeks in advance. Observations of program/site operations will be unannounced. The auditing schedule will be prepared in advance and cover a calendar year. Any modifications to the monitoring schedule must be approved by the Compliance Officer.

2. Investigations as a result of a Compliance Line call will not be scheduled with the program/site prior to the monitoring visit.

3. For record review purposes the Quality Assurance Department will utilize monitoring/audit tools that pertain to the program/site specific regulations.

PROCEDURE

Monitoring/audit visits will take place at the program/site. Under certain circumstances, a record review may be required to be performed at the Pathways, Inc. Administrative offices; in this case, the records would be transported to this location. When the program is utilizing Electronic Health Records, audits may be completed via a desk top review from the QA Departments main office.

The number of records reviewed will depend on the individual program/site needs and risk areas. The agency compliance work plan will establish the auditing percentages to be completed at routine quarterly audits.

Audit Reports

As follow up to the monitoring/audit, the Quality Assurance Department will generate a monitoring/audit report and distribute it to the appropriate site designee.

The Quality Assurance Department will copy the report to the Executive Vice President who oversees the program/site, the Chief Operating Officer and to the President & CEO.

The Compliance Officer will report to the Compliance Committee quarterly concerning the results of program/site monitoring. Additionally, all compliance activities are reviewed with the Board of Directors at the monthly BOD meeting.

The Compliance Officer will develop an annual work plan and monitoring schedule identifying all auditing practices to be carried out for the QA Department. The Compliance Officer will maintain the schedule and periodically report to the President & CEO and Board of Directors on the completion of work plan items. In addition to monthly, quarterly and annual work tasks, the plan will identify any risk areas to be added to the work plan on an ongoing basis.

The Quality Assurance Department will maintain a spread sheet identifying all internal / external findings that the department / compliance committee has determined are significant systematic trends. This information will be shared routinely with all affected programs for the purpose of risk mitigation. This information will be used to assist in determining effectiveness.

The Quality Assurance Department will disseminate relevant information at Manager/Quality Management Meetings to include review of an Plans Of Corrective Actions, billing adjustment, trends identified, training of new staff (at all levels), discussion of open positions/excessive overtime, new and or revised training materials and Statement Of Deficiencies received through state implemented audits. Additionally new/revised state issued ADM's, will be discussed for potential effect on programs and need for implementing revisions and trainings to all affected employees.

PATHWAYS, INC. Corporate Compliance Manual	DATE ISSUED 1/1/02	DATE REVIEWED/ REVISED 3/21/23	PAGE 1 of 12	TOPIC NO. 7 CCP
POLICIES AND PROCEDURES MANUAL	FUNCTION: Corporate Compliance Program			
SOURCE/REFERENCE 18 **NYCRR Part 521** 521-1.4(h)	SUBJECT: Responding to Compliance Issues			
	TOPIC: Pathways, Inc. Compliance Committee & Board of Directors			

ELEMENT 7:
Responding to Compliance Issues Pathways, Inc.'s compliance program should be designed and implemented to prevent, detect, and correct non-compliance with Medicaid program requirements, including fraud, waste, and abuse most likely to occur for Pathways, Inc.'s risk areas and organizational experience. Pathways, Inc. can do this by ensuring it has established and implemented procedures and systems for promptly responding to compliance issues, including any issues identified in the course of an internal or external audit.

POLICY
Disciplinary or corrective action in response to substantiated investigations and acts of non-compliance are an integral part of the Compliance Program. If the result of a monitoring/audit report or investigation indicates a discrepancy in billing resulting in an overpayment from Medicaid, prompt corrective action will be taken including repayment within 60 days of the identification of the overpayment. Corrective action and a request for a plan of action will be issued by the Compliance Officer to specific programs/sites if the monitoring/audit report indicates an area of non-compliance related to record keeping standards, or non-compliance with the policy and procedures related to the Compliance program that could result in disallowed costs. The Compliance Officer will report the status of program/site corrective action to the Compliance Committee on a quarterly basis or more frequently as required. The Compliance Officer will be responsible for reporting to the Compliance Committee any indication of trends related to continued non-compliance by a specific program/site or employee. The Compliance Committee can review and or recommend disciplinary action related to any areas of non-compliance related to the Compliance Program.

Pathways Inc. will;

1. Take prompt action to investigate the conduct in question and determining if any corrective action is required.
2. Correct compliance problems promptly and thoroughly to reduce the potential for recurrence.
3. Monitor plans of correction to ensure compliance issues do not recur.
4. Ensure ongoing compliance with state and federal laws, rules, and regulations of the Medicaid program.

5. Promptly report credible evidence that a state or federal law, rule, or regulation has been violated to the appropriate governmental entity. Page 16 of 17 6. Reporting and returning overpayments in accordance with Medicaid self-disclosure program requirements.

PROCEDURE

CRITERIA FOR SUBMITTING A PLAN OF CORRECTIVE ACTION

The plan of Corrective Action (POCA) is an essential component of the Pathways, Inc. internal review process because it is a statement of the program's planned action to correct specific regulatory deficiencies and the actions the program is taking to ensure compliance with regulatory requirements in the future. The request for a POCA will be indicated at the end of the monitoring/audit report. The program will be required to respond in writing to the request for a POCA within seven business days of receipt of the request. The response should be forwarded to the Compliance Officer or compliance660@pathwaysforyou.org and the Executive Vice President responsible for the specific program. The POCA will be reviewed by the QA Department to ensure that root causes are addressed. The Quality Assurance Department will determine the effectiveness of the POCA at the next scheduled review.

All incorrect billings must be reconciled by the program with the Finance Office within the seven business days of the POCA request. In addition the POCA must include the date the reconciliation was made with the Finance Office and the person who submitted the information. The Finance Office will execute the needed billing adjustments and submit documentation of the adjustment to the applicable Manager and to the Compliance Officer or email at compliance660@pathwaysforyou.org

Compliance Investigations

All Compliance Line cases will be handled in a manner that protects the privacy of the caller in that the Agency will not try to track an anonymous call under any circumstances. Employees will not be subject to reprisal for reporting, in good faith, actions that they feel violate the law or established standards. Any employee engaging in any act of reprisal for any good faith reporting may be subject to discipline and or discharge.

All Compliance Line cases will normally be investigated promptly when received. Compliance Line cases will be investigated by the Compliance Officer or persons having a sufficient level of knowledge with regard to the issue presented by the call. All Compliance Line calls will be logged and tracked for informational and reporting purposes and be kept for a period of six years. Disciplinary or corrective action in response to substantiated allegations will be an integral part of the Compliance Line program.

PROCEDURE

1. The intake call will be received directly by the Compliance Officer or, if after hours, by the confidential Compliance Line voice mail. The caller will be asked to give certain information, if the call is on the Compliance line the caller will be directed to leave the information on the voice mail system. When there is a message, a voice mail message light will be indicated to the Compliance Officer. The Compliance officer will have access to this voice mail and act accordingly.

2. The information received from the intake call is documented and entered into a logging system.

3. If the call is a suggestion or general inquiry not related to the Compliance Program, the information will be referred to the appropriate department and an appropriate annotation reflecting this referral would be made in the intake log. These calls will be logged for informational purposes, but a case file will not be created within the Compliance Line Program.

4. After receipt of the intake call the Compliance Officer will do the following

    a. Identify the management for the site named in the call.

    b. Determine if anyone named in the call has been excluded from Medicare/Medicaid contracting by checking the exclusion data base.

c. Prepare a new Compliance Line case file, entering the appropriate data.

5. The Compliance Officer will review the case and determine if additional information is necessary to develop an investigation plan. If additional information is required, the caller, if identified, will be contacted to obtain additional information. If the call is anonymous, the Compliance Officer will evaluate the call to determine if the case can be investigated without obtaining additional information. If it is determined that an anonymous call cannot be investigated without additional information, the case will be discussed with the President & CEO, for determination of appropriate action.

6. If it is determined that there is sufficient information to investigate, the Compliance Officer will examine the case and determine what questions must be answered to resolve the case. In determining or resolving the questions, which must be answered, the Compliance Officer may consult with management associated with the site in question. The questions should address broad policy issues raised by the case rather than merely the allegations raised by the caller.

7. The Compliance Officer or designee will act as the Internal Investigator for suspected violations of the Pathways, Inc. Compliance Program and program regulations. In the event that the Compliance Officer is involved, a Pathways Quality Assurance Specialist will conduct the investigation. The Compliance Officer, with approval of the President & CEO, may consult with legal counsel for advice as to the nature and course of investigations. External investigators will only be used or assigned with the express approval of the President & CEO.
8. The Compliance Officer will determine the appropriate amount of time, which ordinarily will not exceed ten days, to allow for the investigation. Investigations will be pursued diligently and any reporting and returning of overpayments required will be accomplished within 60 days of identification of the overpayment.
9. The Compliance Officer or designee will develop a detailed investigation plan, interview appropriate personnel, and review documents. At the end of the investigation, the Compliance Officer will make a determination of substantiated or unsubstantiated. The results of the investigation will be documented and forwarded to the President & CEO, Compliance Committee, and as appropriate Board President.
10. If the case is substantiated, the findings will be forwarded to the appropriate management staff for the site in question. The Corrective Action Policy would be followed at this point. Substantiated

cases that include billing that has already been submitted will require a full self disclosure statement to be sent to the OMIG. See below

11. For unsubstantiated cases the Compliance officer will contact the appropriate management staff for the site in question and communicate the closeout of the case. The fact that the case was found to be unsubstantiated will be communicated but the identity of the caller will not be disclosed and the specific comments of identified individuals will not be disclosed. For substantiated cases, management will be advised of the results as part of the development of a corrective or disciplinary action plan.

- All reports via the confidential method will be kept confidential whether requested or not.
- All hot line calls will remain confidential unless the matter is turned over to law enforcement.
- All findings will be reviewed by the Compliance Committee

Self Disclosure Policy
Eligibility
Eligibility to participate in the Self-Disclosure Program is detailed in SOS § 363-d(7)(c). To be eligible, a provider must meet all the following criteria:
• Pathways, Inc. must not currently be under audit, investigation, or review by OMIG, unless the overpayment and the related conduct being disclosed does not relate to OMIG's audit, investigation, or review.
• Pathways, Inc. is disclosing an overpayment and related conduct that OMIG has not determined, calculated, researched, or identified at the time of disclosure.
• Pathways, Inc. has reported the overpayment and conduct within sixty (60) days from identification, or by the date any corresponding cost report was due, whichever is later.
• Pathways, Inc. is not currently a party to any criminal investigation conducted by the deputy attorney general for the Medicaid Fraud Control Unit (MFCU), or any agency of the United States government or any political subdivision thereof.

- OMIG has enacted a Self-Disclosure process to allow Pathways, Inc. a mechanism to report, return, and explain overpayments from the Medicaid program. The process covers all Medicaid program providers. See SOS § 363-d(7).

- Overpayment Identification Pursuant to SOS § 363-d (6)(b), an overpayment has been identified when a provider has, or should have, through the exercise of reasonable diligence, determined that Pathways, Inc. received a Medicaid fund overpayment and they have quantified the amount of the overpayment. Providers who have a compliance program should be utilizing routine internal audits to review compliance with Medicaid requirements and identify any Medicaid fund overpayments that may have been received.
- Additionally, if a provider is the subject of a government audit, part of that provider's due diligence is to review the results of the audit and look at past and future periods not covered in the audit scope to identify overpayments resulting from similar issues.
- If overpayments exist, providers are obligated to take corrective action, which includes reporting and returning any Medicaid overpayment identified to OMIG's Self-Disclosure Program.

- Anticipated Timeframes and Process While both Federal and State regulations require a provider to report, return, and explain an overpayment within sixty (60) days from identification, the actual timeframes for processing can vary. A provider's 60-day time frame will be tolled, or paused, when

- a complete Self-Disclosure Statement and Certification is received from an eligible provider. The time frame to repay will remain tolled during OMIG's review.

A self-disclosure submission related to a Medicaid program overpayment requires completion of either a Self-Disclosure **Full Statement** (including a Claims Data File of affected Medicaid claims or Mixed Payer Calculation (MPC) form for Excluded providers, or a completed Self-Disclosure **Abbreviated Statement**. If the Medicaid program overpayment is not related to claim data or is related to an excluded or non-enrolled provider, disclosure using a Self-Disclosure Full Statement and additional explanation to allow for the verification of the overpayment is required. The determination of which form is appropriate for a Medicaid entity's/Provider's self disclosure should be based on the error identified. Errors that require formal corrective Last Updated 08.21.2023 5 Social Services Law § 363-d(7)(e) action plans should always be self-disclosed using the Self-Disclosure Full Statement, while errors that are more transactional or routine in nature and already repaid through voids or adjustments may be better suited to for the Self-Disclosure Abbreviated Statement.

Self-Disclosure Full Statement Examples to be self-disclosed using the Self-Disclosure Full Statement include but are not limited to:
• Any error that requires a Medicaid entity/Provider to create and implement a formal corrective action plan;
• Actual, potential or credible allegations of fraudulent behavior by employees or others;

- Discovery of an employee on the Excluded Provider list;
- Documentation errors that resulted in overpayments;
- Overpayments that resulted from software or billing systems updates;
- Systemic billing or claiming issues;
- Overpayments that involved more than one Medicaid entity/Provider (example – Health Homes & Care Management Agencies);
- Non-claim-based Medicaid overpayments;
- Any error with substantial monetary or program impacts; and
- Any instance upon direction by OMIG. Note: The Self-Disclosure Full Statement includes embedded links to the Claims Data File and MPC form.

For disclosures using the Self-Disclosure Full Statement OMIG requires:

The overpayment amount
- A detailed explanation of the reason the Medicaid entity/Provider received the overpayment or caused the overpayment to be received, including an explanation of the circumstances that led to the overpayment
- Identification of any rule, policy, regulation or statute that was violated
- Identification of the individuals involved in the error and discovery of the error
- The type of Medicaid program affected
- Corrective measures put in place to prevent a recurrence, etc.
- Contact information
- Signature of the disclosing Medicaid entity/Provider on the form Last Updated 08.21.2023 6 Social Services Law § 363-d(7)(e)
- Signatory and Title of the responsible person who will sign the documents
- Claims Data File or MPC form if applicable
- Agreement to the terms of disclosure
- Confirmation that void or adjustment transactions have been processed, or agreement to return the overpayment amount within fifteen (15) days of written notification from OMIG, or if approved by the OMIG, agreement to executing a SDCA to repay in installments The Claims Data File should include the following for each disclosed claim:

Payer Name (Medicaid FFS or MCO/MLTC name)
- Claim Reference Number (CRN) or Transaction Control Number (TCN), a 16- digit number
- Claim Line Number • Medicaid Group ID (if applicable)
- Billing Provider's Medicaid MMIS ID (Billing Provider ID) and NPI number
- Servicing Medicaid MMIS ID (Servicing Provider ID) and NPI number

• Medicaid recipient's first name
• Medicaid recipient's last name
• Medicaid recipient's Medicaid ID number (CIN), an 8-character number (e.g., AA#####A) • Medicaid recipient's Date of Birth
• Medicaid recipient's Social Security Number
• Date of service (not the date billed or payment date)
• Incorrect rate or procedure codes (if applicable)
• Correct rate or procedure codes
• Incorrect Units paid (if applicable)
• Correct Units
• Amount Medicaid paid
• Amount that Medicaid should have paid
• Amount paid by Medicare or any other third party (if applicable) Last Updated 08.21.2023 7 Social

Services Law § 363-d(7)(e) Self-Disclosure Abbreviated Statement Examples to be self-disclosed using the Self-Disclosure Abbreviated Statement:
• Routine credit balance/coordination of benefits overpayments;
• Typographical human errors;
• Routine Net Available Monthly Income (NAMI) adjustments;
• Instance of missing or faulty authorization for services due to human error;
• Instance of missing or insufficient support documentation due to human error;
• Inappropriate rate, procedure or fee code used due to typographical or human error;
• Routine recipient enrollment issue for disclosures using the Self-Disclosure Abbreviated Statement OMIG requires:
• Provider Federal Employer Identification Number (FEIN) or Social Security Number (SSN
• Provider Name or DBA
• Contact Name, title, phone number and email
• Overpayment Identification Period
• TCN(s) of voided or adjusted claim(s)
• Overpayment Reason for each voided or adjusted claim
• Total amount voided or adjusted during the Identification Period
Wait for a response and provide additional information if requested OMIG will review the submission and determine eligibility to participate in the SelfDisclosure Program. For disclosures made through a Self-Disclosure Full Statement, the Medicaid entity/Provider will receive notification from OMIG with a project or case number for reference. OMIG may ask for additional information to process the submission, or to

determine eligibility for an installment payment plan requiring a SDCA. If requested, the Medicaid entity/Provider must respond within the time frame indicated in the request. Failure to do so may result in the determination that the Medicaid entity/Provider has become non-compliant with the Self- Disclosure process. The consequences for failing to cooperate with the Self-Disclosure process are detailed below in section #4 Compliance with the Self-Disclosure Process. 3. Determination and Payment after OMIG's review of all self-disclosure submission material provided in a Self Disclosure Full Statement, the Medicaid entity/Provider will receive a Determination Notice for their disclosure case. Last Updated 08.21.2023 8 Social Services Law § 363-d(7)(e) It is expected that Medicaid entities/Providers will implement the corrective action they have specified in their Self-Disclosure Full Statement to prevent recurrence of the disclosed issue. For those Medicaid entities/Providers required to adopt and implement an effective compliance program, implementation (or failure to implement) corrective action(s) will be taken into consideration during any compliance program review by OMIG. If OMIG determines an overpayment is due, OMIG will send a Determination Notice confirming the overpayment amount, and the instructions regarding repayment.

To remain compliant with the self-disclosure process, payment of the full overpayment amount, plus any interest, must be paid within fifteen (15) days from the date of the Determination Notice, or no later than the expiration of the deadline to report, return, and explain, unless the Medicaid entity/Providers had previously requested and was approved for an installment repayment agreement (SDCA).
Payment can be made by:
• Lump-sum check, money order or electronic check payment. Please do not send payment in with your submission.
• Voids or Adjustments of the overpaid claims.

Self-Disclosure Reporting Process for the Office of Mental Health (OMH) When a provider submits a self-disclosure using the Full Self-Disclosure Process (using the Self-Disclosure Full Statement and Certification), they must report those overpayment to their respective OMH local Field Office representative and the OMH Medicaid Compliance Office at Compliance@omh.ny.gov This correspondence must include the date of determination of the overpayment, the scope of the claims paid (i.e., date range of claims and amount of total overpayment), the site and/or program affected, an explanation of the cause of the overpayment, and all corrective actions implemented to prevent further overpayments. Upon receiving this notice, the OMH Medicaid Compliance Office will review and issue a statement confirming that the oversight agency has been notified. *(Reporting of voids and adjustments where the error had minimal monetary impact reported on the Self-Disclosure Abbreviated Statement are NOT required to be disclosed to OMH.)*

Disclosing Damaged, Lost or Destroyed Records Pursuant to Title 18 of the New York Codes Rules and Regulations, Section 504.3, Pathways, Inc. required to prepare and maintain contemporaneous records demonstrating their right to receive payment under the medical assistance program and furnish the records, upon request. If Pathways, Inc. becomes aware that their records have been damaged, lost or destroyed they are required to report that information to the Self-Disclosure Program as soon as practicable, but no later than thirty (30) calendar days after discovery. Last Updated 08.21.2023 10 Social Services Law § 363-d(7)(e) How to Report A submission for lost, destroyed, or damaged records requires completion of a Statement of Lost or Destroyed Records form and submission of any accompanying documentation to support the report of loss or damaged records. For reports of lost,
destroyed, or damaged records OMIG requires:

- A detailed explanation of the event that caused the loss, destruction, or damage of records and
- Identification of the records affected including document type, Medicaid recipients affected, dates of service; etc. and

Identification of the steps taken to report the lost, destroyed, or damaged records. OMIG's Response A notification letter detailing the acceptance of the report will be issued to Pathways, Inc. or Pathways, Inc.'s authorized representative. Recordkeeping OMIG's receipt and acknowledgement of a provider's Self-Reporting Notification does not absolve Pathways, Inc. of its recordkeeping responsibilities. The paid claims and/or program associated with the lost/destroyed records remain available for audit, review, or investigation. OMIG will evaluate whether there are mitigating circumstances for the failure to maintain these documents in conjunction with any audit, review or investigation that involves the reportedly lost/destroyed records

Procedure

The finance office will identify all claims needing a self-disclosure and will add the claim statement to the shared drive QA folder and notify the Compliance Officer.
The QA Department will initiate the self-disclosure process (Full disclosure / Abbreviated) by the 5th day of the following month.
Once submitted the OMIG acknowledgement will be saved in the shared drive QA folder.
Self-disclosure statements will also be saved in the shared drive QA folder.

BILLING ADJUSTMENT PROCEDURE

With our many programs, the Agency has many funding sources. Each requesting certain information about the people served. The timeliness of submitting this information is very important for the financial strength of this Agency. Complete, accurate and legible forms are imperative. The Billing Clerk, the Agency Auditors, Medicaid Auditors, and etc., will review these documents. These reviews could take

place the day after the date on the attendance form, at year-end or even five years after the date of service. Keeping this in mind, you will understand the need for complete names (not nicknames), month, day and year for dates, full process codes, etc.

1. In the event that a billing adjustment is needed under any circumstance, the program Director / Manager involved must complete the billing adjustment form including the top portion of the form and the lower section marked Manager / Director, submit the billing revision form identifying the Individual(s) billed for, the date of service, type of service, Units / hours originally billed for, what the billing is being revised to and a brief explanation as to how the error occurred (be specific). Discussion should occur to verify the most appropriate action to correct the overpayment. The form must be submitted to the billing department immediately upon discovery of the concern. Billing adjustments covering dates of service beyond 90 days must be voided. See attached billing adjustment form.

2. Once the billing department has received the billing adjustment form and made the necessary corrections, the section of the billing adjustment form identifies as "Business Office" will be completed, printed and a copy sent back to the Manager / Director who created the form. The billing department will maintain paper copies of all billing adjustments and will be monitored by the Quality Assurance Department.

3. A billing adjustment form is included with this policy. All sections of the form must be completed. Monthly, the Quality Assurance Department will trend each of the billing adjustment forms as part of a risk analysis. Quarterly the results of the trends will be reviewed with the Compliance Committee. As deemed necessary by the committee, a plan of correction may be requested from the leadership staff covering the program.

PATHWAYS, INC. Corporate Compliance Manual	DATE ISSUED 1/1/02	DATE REVIEWED/ REVISED 3/21/23 9/5/24	PAGE 1 of 12	TOPIC NO. 8 CCP
POLICIES AND PROCEDURES MANUAL	FUNCTION: Corporate Compliance Program			
SOURCE/REFERENCE 18 **NYCRR Part 521**	SUBJECT: Records Management			
	TOPIC: Pathways, Inc. Compliance Committee & Board of Directors			

Topic VIII. Records Management

- **Contemporaneous Notes**
- **Record Retention**
- **Secure Record Storage**
- **Destruction of Records**
- **Unexpected loss, damaged or destroyed Records / Self Disclosure**

Proper record keeping is necessary not only to comply with State and Federal Law, but also to ensure proper treatment and care for the people Pathways, Inc. serves. Federal Law and State Regulations require Pathways, Inc. to maintain financial and participant records necessary to fully disclose the extent of services, care, and supplies provided to Medicaid recipients. Federal Law also imposes strict record keeping requirements. Failure to comply with these laws and regulations may result in recoupment, monetary penalties or exclusion from participation in Federal programs. As a Pathways, Inc. employee, you are expected to ensure that all individual and business records for which you are responsible are accurate and completed on a timely basis. The individual records must contain information to justify admission and continued need for services, support the diagnosis, and describe the individual's progress within the program. All actions and transactions, regardless of whether they are medical, financial, operational, or administrative, must be accurately documented on a timely basis according to Pathways, Inc. Policies and procedures, all applicable federal, state, and local laws, rules, and regulations and any payer requirements. It is particularly important that all employees remember that Pathways, Inc. records are the legal documents, which describe the services individuals receive. They also provide supporting documentation for diagnosis and all Medicaid charges. Therefore, it is imperative that all entries made in individual's records are contemporaneous, complete and accurate, and that services are documented when they are delivered by the person who delivered them. The following record requirements for billing apply to all programs providing services within Pathways Inc. The minimum content of the individual record includes:

- Recipient identification (name, sex, age, Medicaid # etc.);
  Diagnosis, conditions or reasons for which care is provided which may be required in a level of care determination;
- Nature and extent of services provided which may be required in a Service Plan;
- Type of service ordered or recommended for the individual which may be required in a Staff Action Plan;

- The specific dates of service provided and ordered which may be required in certain documentation.
- Case record entries shall be made in non-erasable ink (Blue or Black) or type. (NO PENCIL)
- Case records shall be legible.
- All progress notes and case entries shall be dated and signed by staff providing service. (FULL SIGNATURE, TITLE and DATE)
- White out shall not be used in case records.
- All billable documentation should be completed contemporaneously. Staff have seven days to complete documentation describing services, the date of service is day one. Signatures (wet or electronic) must be implemented on all documentation by the seventh day. Staff training still requests that documentation be completed on the same shift. This allows for program leadership to verify all documentation prior to locking the documentation with the signature. The Compliance Officer and respective Executive Vice President will review requests for signatures to exceed the seven day limit. Additionally, the Compliance Officer and respective Executive Vice President may grant permissions under extenuating circumstances to create documentation exceeding the seven days.

If an error occurs on paper documents during a case record entry, staff shall draw one line through the error and initial and date the error the day the correction was made.

PROCEDURE FOR UNLOCKING AN ELECTRONIC SIGNATURE AND GRANTING BACK DATING PERMISSIONS

If an error occurs in the Electronic Health Record (EHR):

1. Director / Manager / Supervisor prints out a copy of the note needing corrections.
2. Attaches the note to the E-Signature request form to have the electronic note unlocked.
3. Thoroughly completes the signature removal form identifying why the error occurred and submits the request to the respective Executive Vice President overseeing the program.
4. The Executive Vice President and Compliance Officer will verify that the note has not been billed.

5. If The Executive Vice President and Compliance Officer agree that the E-Signature should be unlocked, the Executive Vice President will notify the originator of the request and inform them that the signature is being removed from the document and revisions need to take place immediately.
6. Once the document has been revised, a copy of the revised document will be printed and forwarded to the Compliance Officer to be kept with the original document that generated the request so that the old and new document can be compared for future auditing purposes. Any billing adjustments must be attached to the E-Signature removal request.
7. Once all documentation has been revised, copied and forwarded, the information will be kept on the E-Signature removal log by the QA Department for trending purposes.
8. When a document is being deleted, the Manager or designee will indicate in writing on the original request to remove the E-Signature that the note has been deleted and the date this occurred.
9. All unlocked E-Signatures and backdating permissions will be tracked and trended by the Quality Assurance Department and Corporate Compliance Committee.

For notes that need corrections made in the AWARDS system that do not affect billing, an addendum can be written to the note without unlocking the original note with the error. Addendums are used to clarify information in an existing document. Addendums must match up to the existing note including the date, time and content matching the existing note. Addendums must be detailed as to why an addendum is being added to support the existing note. Supporting documentation / verification to support the addendum may be needed to support billing by uploading in to the electronic file cabinet in the AWARDS system. Billable notes that need corrections to billable components such as time or date should follow the E-Signature removal process. Notes that have been billed for will not have the E-Signatures removed unless the claim in whole is being voided.

Electronic Notes / Backdating Permissions

Pathways, Inc. primarily utilizes the AWARDS & Therap Electronic Health Record Systems. Staff utilizing the system have rules set within the system that allows them the current day plus six additional days to

complete their documentation and up to seven days to electronically sign the documentation (Therap does not have a separate electronic signature; by submitting the information it is considered electronically signed).

The Compliance Officer and respective Executive Vice President have the ability to implement backdating permissions to allow staff the ability on a case by case basis to enter data beyond the seventh day and or make corrections to notes already completed in the system. Backdating permission may be needed for correcting a note, adding an additional note, amending a note, or electronically signing a note. The program will include in the request for this to occur the information needed to substantiate the accuracy of the change. The Compliance Officer and respective Executive Vice President will review the information provided to ensure that the change can be substantiated prior to granting the permission. Once the backdating permission has been granted it will be monitored to ensure that the permission is not used for anything other than what it was granted for and that the permission is removed once the documentation is completed. For EVV there are no restrictions on changing the data points, however, the above noted process will be followed.

Record Storage

Section 521-1.3(b) is added to establish the obligation of Required Providers to retain records relevant to their adoption, implementation and maintenance of a compliance program under the regulation, and to make such records available to OMIG, DOH or the New York State Medicaid Fraud Page 2 of 73 Control Unit (MFCU). It also establishes the record retention period which is consistent with the requirements of 18 NYCRR § 504.3(a) and § 517.3, except that MMCOs shall retain records for a period of 10 years, consistent with the terms of the contracts between the MMCOs and DOH.

Medicaid records include all documents necessary to complete a Medicaid claim or required for a Medicaid claim. Files for current year and previous year will be kept on site at the program. All other records will be kept at the agencies record storage facility at the agency's headquarters. Record storage must be environmentally safe and secured at all times. Access to records must be limited to those who need access for their job responsibilities. All record storage maintained off site will be coordinated by the Compliance Officer. For specific program record storage, refer to program policy and procedures to each program type.

Record Destruction

Pathways, Inc. shall maintain regular systematic methods for the destruction of documents that have exceeded the regulatory requirements for maintaining said documents. Per program policy and procedure aged documents must be destroyed through secure confidential methods approved of by the Compliance Officer and Compliance Committee.

Unexpected Loss, Damaged or Destroyed Records

Providers whose records have been damaged, lost or destroyed are required to report that information as soon as practicable, but no later than thirty (30) calendar days after discovery, to the Office of the Medicaid Inspector General (OMIG) Self-Disclosure Unit. Providers must also notify any other State or local regulatory agency of their loss, damage or destruction as required by those regulatory agencies. Disclosing Damaged, Lost or Destroyed Records Pursuant to Title 18 of the New York Codes, Rules and Regulations, Section 504.3, providers are required to prepare and maintain contemporaneous records demonstrating their right to receive payment under the medical assistance program and furnish the records, upon request. If a provider becomes aware that their records have been damaged, lost, or destroyed, they are required to report that information to the Self-Disclosure Program as soon as practicable, but no later than thirty (30) calendar days after discovery. How to Report a submission for lost, destroyed, or damaged records requires completion of a Statement of Lost or Destroyed Records form, Certification, and submission of any accompanying documentation to support the report of loss or damage.

In the event of a Medicaid audit or investigation in which sought records were not maintained as required by 18NYCRR 504.3, OMIG will evaluate the Statements of Damaged, Lost or Destroyed

For reports of lost, destroyed, or damaged records OMIG requires: • A detailed explanation of the event that caused the loss, destruction, or damage of records; • Identification of the records affected, including document type, Medicaid recipients affected, dates of service, and so forth; and • Identification of the steps taken to report the lost, destroyed, or damaged records.

Records and determine on a case-by-case basis whether there are mitigating circumstances for missing or damaged documents. Each section of the Self-Disclosure Statement must be filled out in its entirety.

General

Please submit one Statement for each location impacted by the event reported.

Contact Information

If additional information is required, OMIG will communicate with you using the contact information requested in Section 2.

Explaining Loss or Destruction of Records

Providers are required to explain the cause(s) of the loss/destruction of records, how and when it was identified, and what actions have been taken to report the loss/destruction and prevent recurrence of the event. Providers must also include any additional documentation supporting this statement such as insurance filings, police reports, correspondence with state or federal entities, and so forth.

POLICY: Record Storage for Medicaid Funded Programs

Pathways, Inc. must prepare and maintain contemporaneous records demonstrating their right to receive payment. "All records necessary to disclose the nature and extent of services furnished and the medical necessity therefore....must be kept by Pathways, Inc. for a period of ten years from the date the care, services or supplies were furnished or billed, whichever is later"
(18 NYCRR §§ 517.3[b]) & 540.7 (a)[8]). This information and related documents regarding claims for payment is subject to audit for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later, except when fraud may be involved or the audit is obstructed. Upon request this information must be furnished to OMIG, DOH, HHS, and/or the Medicaid Fraud Control Unit of the Attorney General's Office. The statute of limitations of the False Claims Act is ten years from the date billed.

In order to maintain files for all Medicaid funded programs, the following guidelines will be adhered to.

Filing Systems:

Each program will consistently file records for the current year on site as identified in policy in a secure filing location.

Files for current year and previous year will be kept on site at the program

All files in the current year filing cabinet should be reviewed at the beginning of the new calendar year and or after the State review. Files will then be transferred into empty "designated record storage boxes" to be labeled and maintained as follows:

1. Each box shall contain 1-years' worth of information for the Individual, up to three Individuals per box for DD residential and up to 20 Individuals per box for DD day services. OMH Waiver boxes will have a maximum of four individuals per box. B2H will have a maximum of four individuals per box.

OMH CR's will maintain one box per youth to remain on site for duration of services. Once discharged files will be maintained on site until the next survey.

2. All paperclips, staples, rubber bands, dividers, and binders must be removed prior to filing into "designated" boxes.

3. Records stored at the agency's headquarters. Each box should be clearly labeled using a black permanent sharpie with the individual's name of files enclosed, year of documents enclosed and month& year to be destroyed. Records will not be sent to the agency's headquarters storage until the box content has been reviewed and verified by the Executive Vice President or designee as verified on the box inventory form and initialed by the staff member verifying the box content.

The content of each box will be filed in the following order:

OPWDD Programs

IPP, Medical, Financial, Miscellaneous. Each individual section will be placed in a paper manila folder separating out each section of information identified in the table of contents. If more than one folder is needed, be sure to keep them consecutive. Day services will separate each person by a colored sheet of paper.

DOH Programs

The content of the boxes will follow the order of the table of contents to each Individual Chart. Paper manila folders will be utilized to store chart contents.

Adult Care Management/Recovery Coordination

The content of the boxes will follow the order of the table of contents to each Individual Chart. Paper manila folders will be utilized to store chart contents.

Children's Care Management

The content of the boxes will follow the order of the table of contents to each Individual Chart. Paper manila folders will be utilized to store chart contents.

Children and Family Treatment Support Services

The content of the boxes will follow the order of the table of contents to each Individual Chart. Paper manila folders will be utilized to store chart contents.

Children's Home and Community Based Services

The content of the boxes will follow the order of the table of contents to each Individual Chart. Paper manila folders will be utilized to store chart contents.

Once the box is ready for storage as verified by designated staff, the Executive Vice President of the program will submit in writing on the records inventory form, the information to the Compliance Officer to be added to the record storage inventory list. The box will then be transported to the designated site location for storage.

The Executive Vice President of Home and Habilitation Services, Residential Services and Community Based Services overseeing the program will assign the responsible person to review the box content and ensure all documentation is able to be shredded. If at any time documentation is discovered that cannot be shredded, the responsible person will turn the documentation in to the Vice President of the program.

The Compliance Officer will arrange for documentation scheduled to be shredded to be gathered on site at the agency's headquarters for designated individuals to review the content of the files to be shredded. The following procedure will be followed:

PROCEDURE

1. The Executive Vice President / designee of the program will review the records storage inventory list and identify what box numbers need to be pulled onsite storage.

2. The Executive Vice President/designee of the program will submit in writing to the Compliance Officer the list of box numbers needing to be pulled on the identified box inventory form.

3. For record destruction once all boxes have been reviewed and verified that the content can be shredded, the staff member verifying will sign the box number log verifying that they reviewed the content and the Compliance Officer will arrange shredding services to pick up.

4. Once shredding has been completed, the Compliance Officer will provide the identified staff who maintains the records inventory list with the list of box numbers shredded so that the shredded inventory list can be updated.

Example of Shredding Schedule:

Date	Date of Records to be Shredded
All 2014 records	January 2025

Retention

Program	Retention	Location of Records
OPWDD IRA	Ten years from the date of service	33 Denison
OPWDD CR	Ten years from the date of service	33 Denison
OPWDD ICF	Ten years from the date of service	33 Denison
OPWDD Day Habilitation	Ten years from the date of service	33 Denison
OPWDD Community Hab	Ten years from the date of service	33 Denison

OPWDD SEMP	Ten years from the date of service	33 Denison
OPWDD Pathways to Employment	Ten years from the date of service	33 Denison

Supplemental Day Hab	Ten years from the date of service	33 Denison
Medicaid Service Coordination	Ten years from the date of service	33 Denison
MSC Willowbrook	Ten years from the date of service	33 Denison
OPWDD Waiver Respite FSS	Ten years from the date of service	33 Denison 33 Denison
NHTD/TBI Service Coordination	Ten years from the date of service	33 Denison
NHTD/TBI (HCSS)	Ten years from the date of service	33 Denison
OMH Waiver	Ten years from the date of service	33 Denison
OMH Community Res	Until one year after the minor participant reaches the age of 21 and the required ten years for OMIG documentation	33 Denison
Pre-School - OCFS	Ten years from the date of service	Pre-School Site
Pre-School – State Ed	Ten years from the date of service	Pre-School Site

Kids Adventure Club	Ten years from the date of service	33 Denison
B2H	30 years from the date of discharge from foster care	33 Denison
TFC	30 years from the date of discharge from foster care	33 Denison
BILT Program	Kept in Connections	N/A
WRAP Services	Kept in Connections	N/A
Supervised Visitation – Chemung County	Kept in Connections	N/A
Supervised Visitation – Steuben County	Kept in Connections	N/A
ECFC	Seven Years	33 Denison
Adult Care Management	Kept in Netsmart	N/A
Recovery Coordination	Kept in AWARDS + Seven years for Eligibility Assessment documentation	33 Denison
Children and Family *Treatment* Support Services	Records must be retained for a minimum period of ten years from the date of the last service provided to child or, in the case of a minor, for at least ten years after the last date of service or three years after reaching the age of majority (18 years) whichever time period is longer.	Kept in AWARDS

Adult HCBS - CORE	Ten years from the date of service	N/A
Children's Care Management	Kept in Netsmart	N/A

Record Retention for Incidents

Program	Retention	Location of Records
OPWDD	10 years from the date of closure or pending audit or litigation	33 Denison
TBI / NHTD	10 years from the date of closure or pending audit or litigation	33 Denison
OMH	Until one year after the minor participant reaches the age of 21 and the required ten years for OMIG documentation	33 Denison

All programs – All files will be maintained if there is a pending audit or ongoing litigation known to the agency.
Revised: February 2025

PATHWAYS, INC. Corporate Compliance Manual	DATE ISSUED 1/1/02	DATE REVIEWED/ REVISED 1/21/14 2/23/23	PAGE 1 of 1	TOPIC NO. 9 CCP
POLICIES AND PROCEDURES MANUAL	FUNCTION: Corporate Compliance Program			
SOURCE/REFERENCE 18 **NYCRR Part 521**	SUBJECT: Billing & Claims Systems			
	TOPIC: Pathways, Inc. Compliance Committee & Board of Directors			

POLICY

To ensure the accuracy of all data collected in connection with submission of claims, and to ensure a complete and accurate audit trail; Pathways, Inc. billing and claim data is stored on a network server that is automatically backed up on a daily basis. In order to prevent the contamination and access of data from outside parties, Pathways, Inc. data system is protected by an external firewall and runs anti-virus and anti-malware software. New York State has enacted a series of computer crime laws that are designed to punish and deter computer crime. In compliance with the law, Pathways, Inc. prohibits unauthorized access to its computer system, either directly or through the firewall. An individual who does not have a legitimate password is unauthorized to gain access to the network. Employee policy also prohibits the destruction or corruption of electronically stored or processed data. Persons who violate these rules will be prosecuted to the full extent of the law.

PROCEDURE

1. All data is stored on a network server and backed up by multiple methods including hard drive storage and also a secure off-site cloud back-up.
2. All PCs and servers connected to the network are continuously protected by anti-virus and anti-malware software.

All Pathways, Inc. employees who have access to the network are assigned an individual password. Employee policy prevents the sharing of individual passwords with any other person. Access to the billing program requires an additional password that is used by billing personnel only.

PATHWAYS, INC. Corporate Compliance Manual	DATE ISSUED 1/1/02	DATE REVIEWED/ REVISED 1/21/14 2/23/23	PAGE 1 of 10	TOPIC NO. 10 CCP
POLICIES AND PROCEDURES MANUAL	FUNCTION: Corporate Compliance Program			
SOURCE/REFERENCE 18 **NYCRR Part 521**	SUBJECT: Regulations			
	TOPIC: Pathways, Inc. Compliance Committee & Board of Directors			

Topic X. Regulations

- **False Claims Act**
- **Deficit Reduction Act**
- **Sanctioned Individuals**

Certification Requirements

Pursuant to New York State Social Services Law (SOS) §363-d, providers are required to certify to the Department upon enrollment in the Medicaid program that they are satisfactorily meeting the requirements of SOS §363-d. Furthermore, compliance with the requirements of SOS §363-d is a condition of payment from the Medicaid program.

Effective immediately, providers are no longer required to complete the annual December certification, commonly referred to as the "SSL Certification," using the form located on the Office of the Medicaid Inspector General's (OMIG) website. Instead, a provider adopting and maintaining an effective compliance program will now record (attest to) this as part of their annual "Certification Statement for Provider Billing Medicaid." This annual certification shall occur on the anniversary date of Pathways, Inc.'s enrollment in Medicaid.

Providers can find their anniversary dates on their initial Medicaid enrollment welcome letters. Additionally, each year, approximately 45-60 days before the anniversary of a provider's enrollment, the NYS Department of Health (NYSDOH) sends by mail a package of information and materials to Pathways, Inc., which includes the Certification of Statement for Provider Billing Medicaid Form. This Form must be completed and returned to NYSDOH by the enrollment anniversary date.

The Deficit Reduction Act is federal legislation that places more emphasis on fraud detection and protection. This law is expected to encourage individual states to enact "qui tam" or Whistleblower provisions for persons to report fraud and abuse. The law requires that protections are provided to Whistleblowers to prevent retaliation for reporting fraud.

The law also requires training and education of staff in the False Claims Act and Whistleblower provisions.

All Pathways, Inc Employees will be aware as noted in the Employee Handbook & Code of Conduct that there can be criminal or civil prosecution for a wide range of conduct that leads to the submission of a false claim. They will need to know that there are ways to report false claims. Should an employee report, in good faith, knowledge of an alleged false claim, the employee is protected from retaliation or discrimination for making such a report. The agency has developed policies and procedures related to the False Claims Act and the reporting of non-compliance. Pathways, Inc. strictly prohibits any form of retaliation against an employee who reports a possible false claim.

Under this law, Pathways, Inc. can expect more enforcement of Medicaid laws and regulations at the federal and state level.

The Deficit Reduction Act (DRA) requirements have been incorporated into SOS §363-d. As a result, there is no longer a separate DRA certification requirement. By submitting the annual "Certification Statement for Provider Billing Medicaid," providers are attesting to satisfactorily meeting the requirements of SOS §363-d, which includes the DRA.

All providers who are subject to the mandatory compliance program requirements in SOS §363-d will be impacted by these changes.

Questions regarding this notice should be directed to OMIG's Bureau of Compliance at compliance@omig.ny.gov

Section 1902(a)(68) of the Social Security Act Employee Education About False Claims Recovery.

An "employee" includes any officer or employee of Pathways, Inc.

A "contractor" or "agent" includes any contractor, subcontractor, agent, independent contractor or other person which or who, on behalf of Pathways, Inc., furnishes, or otherwise authorizes the furnishing of Medicaid health care items or services, performs billing or coding functions, or is involved in monitoring of health care provided by the entity.

It is the responsibility of Pathways, Inc. to establish and disseminate written policies which must also be adopted by its contractors or agents. Written policies may be on paper or in electronic form, but must be readily available to all employees, contractors, or agents.
Pathways, Inc. shall establish written policies for all employees (including management), and of any contractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in section 1902(a)(68)(A). Pathways, Inc. shall include in those written policies detailed information about the entity's policies and procedures for detecting and preventing waste, fraud, and abuse. The entity shall also include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers and a specific discussion of the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

Sanctioned Individuals
The OMIG may sanction some providers by excluding them from participating in the Medicaid program. These providers are excluded from offering services to Medicaid enrolees and also cannot be paid with Medicaid dollars. Prior to adding new staff members, Pathways, Inc. will check to see if prospective employees have been excluded from Medicaid. Through the use of a web based program, Pathways, Inc. will conduct a monthly search of the Federal OIG, SAM, Treasury Databases and OMIG databases of all staff and contractors for excluded individuals. If Pathways, Inc. discovers that a member of Pathways, Inc. has been sanctioned, the agency will take immediate action to address the violation and ensure overpayment has not occurred.

Pathways, Inc. is committed to prompt, complete and accurate billing of all services provided to individuals. Pathways, Inc. and its employees, contractors and agents shall not make or submit any false or misleading entries on any claim forms. No employee, contractor or agent shall engage in any arrangement or participate in such arrangement at the direction of another person, including any supervisor or manager that result in the submission of a false or misleading entry on claims forms or documentation of services that result in the submission of a false claim.

It is the policy of Pathways, Inc. to detect and prevent fraud, waste and abuse in federal healthcare programs. This Policy explains the Federal False Claims Act (31 U.S.C. §§ 3729 – 3733), the Administrative Remedies For False Claims (31 USC Chapter 38 §§3801-3812), the New York State False Claims Act (State Finance Law §§187-194) and other New York State laws concerning false statements or claims and employee protections against retaliation. This policy also sets forth the procedures

Pathways, Inc. has put into place policies and procedures to prevent any violations of federal or New York State laws regarding fraud or abuse in its health care programs.

FALSE CLAIMS ACT AND WHISTLEBLOWER PROVISIONS

This policy applies to all employees, including management, contractors and agents.

For purpose of this policy, a contractor or agent is defined as:

- Any contractor, subcontractor, agent, or other person which or who, on behalf of the Agency, furnishes, or otherwise authorizes the furnishing of Medicaid health care items or services, performs billing or coding functions; or
- Is involved in the monitoring of health care provided by the Agency.

Overview of Relevant Laws:

I. The False Claims Act (31 U.S.C. §§ 3729-3733)

The False Claims Act is a federal law designed to prevent and detect fraud, waste and abuse in federal healthcare programs, including Medicaid and Medicare. Under the False Claims Act, anyone who "knowingly" submits false claims to the Government is liable for damages up to three times the amount of the erroneous payment plus mandatory penalties of $5,500 to $11,000 for each false claim submitted.

The law was revised in 1986 to expand the definition of "knowingly" to include a person who:

- Has actual knowledge of falsity of information in the claim;
- Acts in deliberate ignorance of the truth or falsity of the information in the claim; and
- Acts in reckless disregard of the truth or falsity of the information in a claim.

False Claims suits can be brought against individuals and entities. The False Claims Act does not require proof of a specific intent to defraud the Government. Providers can be prosecuted for a wide variety of conduct that leads to the submission of a false claim.

Some examples include:

- Knowingly making false statements;
- Falsifying records;
- Submitting claims for services never performed or items never furnished;
- Double-billing for items or services;
- Using false records or statements to avoid paying the Government;
- Falsifying time records used to bill Medicaid; or
- Otherwise causing a false claim to be submitted.

Whistleblower or "Qui Tam" Provisions:

In order to encourage individuals to come forward and report misconduct involving false claims, the False Claims Act contains a "Qui Tam" or whistleblower provision.

The Government, or an individual citizen acting on behalf of the Government, can bring actions under the False Claims Act. An individual citizen, referred to as a whistleblower or "Relator," who has actual knowledge of allegedly false claims may file a lawsuit on behalf of the U.S. Government. If the lawsuit is successful, and provided certain legal requirements are met, the whistleblower may receive an award ranging from 15% - 30% of the amount recovered.

Employee Protections:

The False Claims Act prohibits discrimination by Pathways, Inc. against any employee for taking lawful actions under the False Claims Act. Any employee who is discharged, demoted, harassed, or otherwise discriminated against because of lawful acts by the employee in False Claims actions is entitled to all relief necessary to make the employee whole. Such relief may include reinstatement, double back pay, and compensation for any special damages, including litigation costs and reasonable attorney fees.

II. Administrative Remedies for False Claims (31 USC Chapter 38. §§3801-3812).

This federal statute allows for administrative recoveries by federal agencies including the Department of Health and Human Services, which operates the Medicare and Medicaid Programs. The law prohibits the submission of a claim or written statement that the person

knows or has reason to know is false, contains false information or omits material information. The agency receiving the claim may impose a monetary penalty of up to $5,000 per claim and damages of twice the amount of the original claim.
Unlike the False Claims Act, a violation of this law occurs when a false claim is submitted, not when it is paid. Also unlike the False Claims Act, the determination of whether a claim is false, and imposition of fines and penalties is made by the administrative agency and not by prosecution in the federal court system.

III. New York State Laws

***A.* Civil and Administrative Laws**
New York State False Claims Act (State Finance Law §§187-194).

The New York State False Claims Act closely tracts the federal False Claims Act. It imposes fines on individuals and entities that file false or fraudulent claims for payment from any state or local government, including health care programs such as Medicaid. The penalty for filing a false claim is $6,000 - $12,000 per claim and the recoverable damages are between two and three times the value of the amount falsely received. In addition, the false claim filer may be responsible for the government's legal fees.

The Government, or an individual citizen acting on behalf of the Government (a "Relator"), can bring actions under the New York State False Claims Act. If the suit eventually concludes with payments back to the government, the party who initiated the case can recover 25% - 30% of the proceeds if the government did not participate in the suit, and 15-25% of the proceeds if the government did participate in the suit The New York State False Claims Act prohibits discrimination against an employee for taking lawful actions in furtherance of an action under the Act. Any employee who is discharged, demoted, harassed, or otherwise discriminated against because of lawful acts by the employee in furtherance of an action under the False Claims Act is entitled to all relief necessary to make the employee whole.

Social Service Law §145-b False Statements

It is a violation to knowingly obtain or attempt to obtain payment for items or services furnished under any Social Services program, including Medicaid, by use of a false statement, deliberate concealment or other fraudulent scheme or device. The State or the local Social Services district may recover up to three times the amount of the incorrectly paid claim. In the case of non-monetary false statements, the local Social Service district or State may recover three times the amount incorrectly paid. In addition, the Department of Health may impose a civil penalty of up to $10,000 per violation. * Note – Effective August 1, 2016 the False Claims Act civil penalty will increase to a range of $10,781 to $21,563 per claim. Also on August 1, 2016, the Administrative Remedies civil penalty will change to $10,781 per claim.If repeat violations occur within five years, a penalty up to $30,000 may be imposed if they involve more serious violations of the Medicaid rules, billing for services not rendered, or providing excessive services.

Social Service Law §145-c Sanctions

If any person applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement, or intending to do so, the person's and the person's family needs are not taken into account for a period of six months to five years, depending upon the number of offenses.

B. Criminal Laws

Social Service Law §145 Penalties
Any person who submits false statements or deliberately conceals material information in order to receive public assistance, including Medicaid, is guilty of a misdemeanor.

Social Service Law § 366-b, Penalties for Fraudulent Practices
Any person who, with intent to defraud, presents for payment any false or fraudulent claim for furnishing services or merchandise, knowingly submits false information for the purpose of obtaining Medicaid compensation greater than that to which he/she is legally entitled to, or knowingly submits false information in order to obtain authorization to provide items or services shall be guilty of a Class A misdemeanor.

Any person who obtains or attempts to obtain, for himself or others, medical assistance by means of a false statement, concealment of material facts, impersonation, or other fraudulent means is guilty of a Class A misdemeanor.

Penal Law Article 155, Larceny
The crime of larceny applies to a person who, with intent to deprive another of property, obtains, takes or withholds the property by means of a trick, embezzlement, false pretense, false promise, including a scheme to defraud, or other similar behavior. This law has been applied to Medicaid fraud cases. Depending on the amount involved, a person may be guilty of a Class A misdemeanor to a Class B felony.

Penal Law Article 175, Written False Statements
There are four crimes in this Article that relate to filing false information or claims. Actions include falsifying business records, entering false information, omitting material information, altering an agency's business records, or providing a written instrument (including a claim for payment) knowing that it contains false information. Depending upon the action and the intent, a person may be guilty of a Class A misdemeanor or a Class E felony.

Penal Law Article 176, Insurance Fraud
This Article applies to claims for insurance payment, including Medicaid or other health insurance. The six crimes in this Article involve intentionally filing a false insurance claim. Under this article, a person may be guilty of a felony for false claims in excess of $1,000.

Penal Law Article 177, Health Care Fraud
This Article establishes the crime of Health Care Fraud. A person commits such a crime when, with the intent to defraud Medicaid (or other health plans, including non-governmental plans), he/she knowingly provides false information or omits material information for the purpose of requesting payment for a health care item or service and, as a result of the false information or omission, receives such a payment in an amount to which he/she is not entitled. Health Care Fraud is punished with fines and jail time based on the amount of payment inappropriately received due to the commission of the crime.

New York Labor Law §740
An employer may not take any retaliatory personnel action against an employee if the employee discloses information about the employer's policies, practices or activities to a regulatory, law enforcement or other similar agency or public official.
This law offers protection to an employee who:

- discloses, or threatens to disclose, to a supervisor or to a public body an activity, policy or practice of the employer that is in violation of law, rule or regulation that presents a substantial and specific

- danger to the public health or safety, or which constitutes health care fraud (knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions);
- provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into any such violation of a law, rule or regulation by the employer; or
- objects to, or refuses to participate in any such activity, policy or practice in violation of a law, rule or regulation.

The employee's disclosure is protected under this law only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation. The law allows employees who are the subject of a retaliatory action to bring a suit in state court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees. If the employer is a health care provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of $10,000 on the employer.

New York Labor Law §741

Under this law, a health care employer may not take any retaliatory action against an employee if the employee discloses certain information about the employer's policies, practices or activities to a regulatory, law enforcement or other similar agency or public official. Protected disclosures are those that assert that, in good faith, the employee believes constitute improper quality of patient care.

The employee's disclosure is protected under this law only of the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation, unless the danger is imminent to the public or patient and the employee believes in good faith that reporting to a supervisor would not result in corrective action. If the employer takes a retaliatory action against the employee, the employee may sue in state court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees. If the employer is a health care provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of $10,000 on the employer.

Policy:

1. Pathways, Inc. will provide training in this policy and procedure to all its employees, contractors and agents. This training will be provided to all new employees as part of the new employee orientation.
2. Pathways, Inc. will perform billing activities in a manner consistent with the regulations and requirements of third party payers, including Medicaid and Medicare.

3. Pathways, Inc. will conduct regular auditing and monitoring procedures as part of its efforts to assure compliance with applicable regulations.
4. Any employee, contractor or agent who has any reason to believe that anyone is engaging in false billing practices or false documentation of services is expected to report the practice according to Pathways, Inc. Reporting of Compliance Concerns and Non-Retaliation Policy and Procedure.
5. Any form of retaliation against any employee who reports a perceived problem or concern in good faith is strictly prohibited.
6. Any employee who commits or condones any form of retaliation will be subject to discipline up to, and including, termination.

Procedures:

The Compliance Officer will ensure that all employees and agents receive training related to the contents of this policy and the False Claims Act. The Compliance Officer will ensure that records are maintained to document the receipt of training.

The Compliance Officer will assure that this policy and procedure is readily available to any outside contractors or agents (as defined by this policy).

The Employee Handbook contains a specific discussion of the False Claims Act. And Deficit Reduction Act