Senior Whole Health of Massachusetts 2022 Fraud, Waste, and Abuse Plan

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Section 1

1.0 Introduction and Purpose

Senior Whole Health of Massachusetts (SWH) is a subsidiary of Molina Health Care, Inc (Molina). SWH is dedicated to the detection, prevention, investigation, and reporting of potential health care fraud, waste, and abuse. Accordingly, and under the direction of Molina, SWH has established a comprehensive Fraud, Waste, and Abuse Plan, also referred to as the "FWA Plan." The FWA Plan has been instituted in accordance with the following federal and state statutes and regulations:

- 42 C.F.R. §455 et seq.
- 42 C.F.R Subpart H
- 42 C.F.R §438.608(a)
- 42 U.S.C. 1396 et seq.
- Deficit Reduction Act of 2005- section 6032
- MassHealth regulations- 130CMR 450.205(F)(1) and 450.223(C)(7)

The FWA Plan has been developed to comply with all standards set forth by the Massachusetts Executive Office of Health and Human Services (EOHHS) and MassHealth. The FWA Plan is revised annually, with revisions made as necessary. SWH shall supply a copy of the FWA Plan to EOHHS and MassHealth as requested.

1.1 Definitions

Fraud is the intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Abuse means practices that are inconsistent with sound fiscal, business, or medical practices that result in an unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.

Waste is health care spending that can be eliminated without reducing the quality of care.

1.2 Assigned Individual Responsible for Carrying Out the FWA Plan

SWH's Compliance Officer is the individual within the organization who is responsible for ensuring the health plan is abiding by the FWA Plan. The Compliance Officer, along with the

health plan's Special Investigation Unit (SIU) has the responsibility and authority to report all investigations resulting in reasonable suspected or confirmed acts of fraud, waste, and abuse by providers to EOHHS, the Massachusetts Medicaid Fraud Control Unit (MFCU), and/or the Center for Medicare & Medicaid Services (CMS), when applicable for Medicare related investigations.

Contact information for the Compliance Officer is as follows:

Rohit Gupta
VP, Enterprise Compliance, Medicare
Molina Healthcare, Inc.
200 Oceangate, suite 100
Long Beach, CA, 90802
Phone number: 909-659-5978
E-Mail: Rohit.Gupta2@MolinaHealthcare.com

Molina's SIU supports the health plan Compliance Officer in preventing, detecting, investigating, and reporting all suspected, potential or confirmed fraud, waste, and abuse to EOHHS, MassHealth and MFCU. The Compliance Officer works in cooperation with EOHHS, MassHealth and other state and federal regulatory and/or law enforcement agencies in investigations of suspected fraud, waste, and abuse as necessary.

Molina's SIU is led by the Associate Vice President of Fraud Waste, and Abuse (AVP-FWA) who is responsible for SIU development, implementation, and together with three Directors of Operations is responsible for oversight of daily activity. Contact information is as follows:

Scott Campbell, CFE
Associate Vice President, Fraud, Waste, and Abuse
Molina Healthcare, Inc.
200 Oceangate, Suite 100
Long Beach, CA 90802
Phone number: (310) 221-3170
E-mail: scott.campbell@molinahealthcare.com

The AVP-FWA serves under the VP-Payment Integrity within the Payment Integrity Office of Molina and is a subject matter expert regarding health care fraud, waste, and abuse. Along with the Directors of Oversight and Operations developing and maintaining SIU systems and processes, the position is also responsible for providing leadership and directives regarding fraud, waste, and abuse to internal and external entities.

The AVP - FWA and Directors of Vendor Oversight and Operations oversee the following staff:

- **SIU Managers**, who are responsible for end to end investigative functions. Reporting to the SIU Manager are Investigators, coders, and Clerks.

- **SIU Clinician Manager**, who oversees the SIU RN Investigators. The SIU RN Investigators are subject matter experts in the area of medical record review and coding.
- **SIU Coding Manager**, who conducts oversight of the SIU Coding Analysts, who are responsible for conducting audits involving provider fraud, waste, and abuse related to coding and/or billing issues.
- **SIU Supervisor**, who is responsible for the oversight of the intake and reporting team analysts, which includes the initial triage of the fraud hotline (AlertLine) and regulatory reporting.
- **SIU Investigator**, who conducts FWA investigations based on leads generated from data analysis, law enforcement and regulatory referrals, assists with onsite audits, and other FWA detection activities under the direction of the SIU Manager.
- **SIU Data Analysts**, are responsible for special data analytics projects assessing potential FWA.

An organizational chart depicting the SIU is included as Attachment A.

1.4 Cooperation with Regulatory and/or Law Enforcement Agencies

Molina's SIU supports the health plan Compliance Officer in preventing, detecting, investigating, and reporting all suspected, potential or confirmed fraud, waste, and abuse to EOHHS, MassHealth and/or MFCU. SWH will cooperate fully in any investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. Such cooperation shall include, but may not be limited to performance of data analysis by SWH as requested by MassHealth or its designee in support of FWA efforts, providing, upon request, information, access to records, access to automated payment and information management systems, access to proprietary fee schedules, and access to interview SWH's employees and consultants, including but not limited to those with expertise in the administration of the program and/or in medical or pharmaceutical questions or in any matter related to an investigation. SWH may be asked to perform an audit to determine its losses. This information will be provided judiciously.

SWH and its subcontractors and providers shall allow EOHHS or any authorized state or federal agency or duly authorized representative with access to SWH and its subcontractors and providers' premises during normal business hours to inspect, review, audit, investigate, monitor, or otherwise evaluate the performance of SWH and its subcontractors and providers. SWH and its subcontractors and providers will cooperate fully in any investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal, to include promptly supplying all data and information requested for the investigation at no cost to the requesting agency. Records includes but is not limited to: medical records; billing records; financial records; any record related to an administrative, civil, or criminal investigation or prosecution; and, any record of a SWH-paid claim or encounter, or a SWH-denied claim or encounter.

SWH will maintain all records, documents, and claim data for enrollees, providers, and subcontractors who are under investigation by any state or federal agency in accordance with

retention rules until the investigation is complete and the case is closed by the investigating state or federal agency. Further, SWH shall suspend its own investigation and all program integrity activities if notified in writing to do so by any applicable state or federal agency. SWH will also comply with directives resulting from the state or federal agency investigations.

Further, upon request, SWH and its subcontractors and providers shall provide and make staff available to assist in such inspection, review, audit, investigation, monitoring or evaluation, including the provision of adequate space on the premises to reasonably accommodate EOHHS or other state or federal agency.

1.5 SIU Policies and Procedures

The SIU has developed several policies and procedures that address the processes to be taken by the unit related to fraud, waste, and abuse investigations. The policies and procedures maintained by the SIU are as follows:

- P-MHI-SIU-101 Administrative Actions
- P-MHI-SIU-102 Opening and Conducting Investigations
- P-MHI-SIU-103 Processing Medical Record Requests for Investigations
- P-MHI-SIU-104 Conduct Clinic Coding Medical Record Audits
- P-MHI-SIU-105 Requests for Information
- P-MHI-SIU-106 Internal Requests for Information
- P-MHI-SIU-107 Referral to a Law Enforcement or Regulatory Agency
- P-MHI-SIU-108 Organizing a Case File

Policies and procedures maintained by Molina's Compliance department to support Molinas's compliance program and fraud and abuse plan include:

- C-02 Anti-Fraud Plan
- C-05 Compliance Committee
- C-07 Molina Healthcare AlertLine
- C-08 Reporting Questionable Accounting and Auditing Matters
- C-09 Review of Compliance Plan
- C-10 Compliance Training
- C-11 Deficit Reduction Act of 2005
- C-13 Compliance Internal Audit Process
- C-14 Remediation Requirements
- C-16 Disciplinary and Corrective Action – Employees
- C-20 Deficit Reduction Act Section 6032 Entity Oversight

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Section 2

2.0 Education of Employees, Providers and Members

2.0.1 Employees[1]

Molina provides training for employees, to include the Compliance Officer, on recognition, detection, prevention, and reporting of suspected activities of fraud, waste, and abuse. In addition, Molina maintains a written "Code of Business Conduct and Ethics" that addresses Molina's commitment to detecting, preventing, and investigating fraud, waste, and abuse. The "Code of Business Conduct and Ethics" can be found in Attachment B.

In accordance with Molina's anti-fraud and Deficit Reduction Act policies, new employees, within 60 calendar days of employment, and existing employees on an annual basis must complete anti-fraud training delivered through Molina's iLearn system. The anti-fraud training reinforces and expands upon the fraud, waste, and abuse training provided to new employees during employee orientation. The anti-fraud training addresses:

- The impact of fraud, waste, and abuse on health care.
- The definitions of fraud, waste, and abuse.
- The Deficit Reduction Act and False Claims Act.
- Employees' obligations to report potential fraud, waste, and abuse.
- The "Whistleblower Provision" and what it means.
- Molina's policy on non-retaliation for reporting potential fraud.
- How to report suspected fraud, waste, and abuse.

All employees must complete a post-test through iLearn. For employees to receive credit for the training year, they must pass the post-test with a score of 100 percent. Employees who fail the post-test must continue to retake the exam until achieving a passing score.

Compliance maintains electronic reports of employee training completed via the iLearn system in order to track compliance with Molina's training requirements. Additional training logs are maintained for training delivered by compliance staff.

Molina, including SWH, commitment to employee training also includes wall posters placed in conspicuous places that provide information regarding what types of information may be reported to Compliance as well as internal and external Compliance Hotline numbers. An image of the poster is included as Attachment C.

[1] Molina checks employees against exclusion lists prior to hire and monthly thereafter.

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2.0.2 Providers

Education on fraud, waste, and abuse is contained in Molina's as well as SWH's Provider Manual. The Provider Manual includes information on the following

- Deficit Reduction Act,
- False Claims Act
- Fraud and abuse definitions.

The Provider Manual also includes:

- Examples of fraud and abuse.
- Instructions for reporting suspected provider and member fraud, waste, and abuse to SWH.

The Provider Manual is used as the basis for new provider orientation sessions conducted by Provider Services. Information contained in the Provider Manual is also available to providers online at www.seniorwholehealthma.com.

2.0.3 Members

SWH's website contains specific instructions for reporting suspected member and provider fraud, waste, and abuse to SWH, definitions of fraud, waste, and abuse, examples of health care fraud, waste, and abuse.

Section 3

3.0 Confidential Reporting of Suspected Fraud, Waste, and Abuse

SWH utilizes several mechanisms to encourage anonymous, confidential and private, good faith reporting of instances of suspected fraud, waste, and abuse. SWH maintains confidential reporting mechanisms that SWH employees, members, providers, vendors, subcontractors and first tier downstream and related entities can use to report suspected fraud, waste, and abuse. The Molina Healthcare AlertLine, which is also used by SWH, is available 24/7 and can be reached at any time (day or night), over the weekend, or even on holidays. To report an issue by telephone, call toll-free at (866) 606-3889. To report an issue online, visit https://molinahealthcare.AlertLine.com. In addition to the Molina Healthcare AlertLine, employees may still report issues of concern directly to their supervisor, Compliance Department, or the Legal department.

SWH trains all employees on the various reporting mechanisms during new employee orientation and thereafter on an annual basis and as needed. Employees are instructed they are required to report all suspected or potential fraud, waste, and abuse.

Employees are encouraged to provide the following information for reporting purposes whenever possible:

Type of Information	Details Required
Complainant(s) Identity	• For the person making the complaint, this should include his/her name, including aliases or alternative name(s). • Address • Contact numbers (e.g., work, home, & cell). • Email address • Identification number and/or date of birth if the complainant is a health plan member.
Relationship to Suspect	• What is the relationship between the person making the report/referral and the reported suspect?
Suspect's Identity	• Suspect name(s), including aliases or alternative name(s). • Address • Contact numbers (e.g., work, home, & cell). • Email address • Identification number (e.g., NPI, Member ID #, TIN)
Witnesses	• Witness name(s) • Address • Contact numbers (e.g., work, home, & cell). • Email address • Witness relationship to the suspect.
When Did the Allegation Occur	• Provide dates and times.
Where Did the Allegation Occur	• Provide location(s).
What Did the Allegation Involve	• A complete description of the allegation, including the type of fraud, waste, or abuse that is being alleged.
How did the Allegation Occur	• How did the situation transpire?

In addition, posters displaying the Compliance Hotline number are placed in conspicuous areas in SWH's offices, instructing staff to report not only compliance, but fraud related issues as well. An image of the poster is included as Attachment C.

Members are informed of the reporting mechanism on the SWH website.

Molina's policy prohibits retaliatory acts by Molina and its subsidiaries against any employee, member or other individual for the exercise of any right or participation in any process established by applicable law. This policy provides for disciplinary action against any employee in violation of this policy.

Section 4

4.0 Fraud, Waste, and Abuse Prevention and Detection Methods

SWH uses various methods for preventing and detecting member, provider and subcontractor fraud, waste, and abuse in the administration and delivery of services related to the Medicaid and Medicare contracts, including but not limited to oral or written reports by providers, members, and employees. Additionally, SWH reviews provider contract status, employs claims audits and analysis, claims system edits and flags, profiling software analysis and reporting, and audits of providers' billing practices and service patterns to prevent and detect potential fraud, waste, and abuse. As part of continuous quality improvement, SWH will work with EOHHS and MassHealth to further develop prevention and detection mechanisms and best practices in order to monitor outcomes for Medicaid.

4.0.1 Credentialing and Licensure

The scope and structure of SWH's credentialing and re-credentialing process is consistent with EOHHS, MassHealth, and federal regulations, including 42 C.F.R. §438.214(b), relating to credentialing of providers. SWH shall include program integrity compliance requirements in its subcontracts and provider application credentialing and re-credentialing processes.

Initial credentialing is completed before the effective date of the initial contract with a provider and includes verification of application. The re-credentialing process occurs not less than every three years following initial credentialing to ensure program conformance with state standards and regulations.

4.0.2 Review of Providers

The Credentialing Department is responsible for monitoring practitioners through various government reports, including:

- Department of Health and Human Services Office of Inspector General List of Excluded Individuals and Entities (OIG-LEIE)
- The Federal government web-based System for Award Management (SAM)
- State Medicaid agency exclusion lists
- Centers for Medicare and Medicaid (CMS) Preclusion Lists

SWH does not knowingly contract with any provider excluded from state or federal programs.

Providers who have been terminated by any state or federal controlling agency for Medicaid and/or Medicare fraud and abuse and/or are currently under exclusion shall not be allowed to participate in the Medicaid Managed Care Program.

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SWH is required to terminate providers/subcontractors for cause in accordance with federal regulations found at 42 CFR §455.416 and Department policies and to report these terminations to EOHHS. SWH will notify EOHHS of any discovered exclusion or an employee, contractor, or provider within two business days of discovery.

SWH shall investigate and disclose to EOHHS at contract execution or renewal, and upon request of EOHHS, the identity of any person who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs and who is an agent or person who has been delegated the authority to obligate or act on behalf of SWH.

4.0.3 Ownership and Control

4.0.3.1 Disclosure by SWH

SWH must disclose to EOHHS:

- The identification of any person or corporation with a direct, indirect, or combined direct/indirect ownership interest of 5% or more of SWH's or subcontractor's equity;
- The identification of any person or corporation with an ownership interest of 5% or more of any mortgage, deed of trust, note or other obligation secured by SWH if that interest equals at least 5% of the value of SWH's assets (or, in the case of a subcontractor's disclosure, a corresponding obligation secured by the subcontractor equal to 5% of the subcontractor's assets);
- The name, address, date of birth, and Social Security number of any managing employee of SWH. For MassHealth purposes, "managing employee" means a general manager, business manager, administrator, director or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

The disclosures must include the following:

- The name, address, and financial statement(s) of any person (individual or corporation) that has 5% or more ownership or control interest in SWH.
- The name and address of any person (individual or corporation) that has 5% or more ownership or control interests in any of SWH's subcontractors.
- SWH must indicate whether the individual/entity with an ownership or control interest is related to any other SWH employee such as a spouse, parent, child, or sibling; or is related to one of SWH's officers, directors, or other owners.
- SWH must indicate whether the individual/entity with an ownership interest owns 5% or greater in any other organizations.

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- The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.
- Date of birth and Social Security number (in the case of an individual).
- Other tax identification number (in the case of a corporation) with an ownership or control interest in SWH or its subcontractor.

SWH must terminate or deny network participation if the provider, or any person with 5% or greater direct or indirect ownership interest in the provider fails to submit requested information within 35 days when requested by MassHealth or any authorized federal agency.

Disclosures from SWH are due to MassHealth at the following times:

- Upon the submission of a proposal in accordance with the state procurement process.
- Upon executing a contract with MassHealth.
- Upon renewal or extension of the contract with MassHealth; and
- Within 35 days after any change in ownership.

4.0.3.2 Disclosure by SWH: Information on Ownership and Control – Subcontractors and Providers

SWH shall include the following provisions in its written agreements with all subcontractors and providers who are not individual practitioners or a group of practitioners:

- Requiring the subcontractor or provider to disclose to SWH upon contract execution, upon request during the re-validation of enrollment process, and within 35 business days after any change in ownership of the subcontractor or provider.
- The name and address of any person (individual or corporation) with an ownership or control interest in the subcontractor or provider.
- If the subcontractor provider is a corporate entity, the disclosure must include primary business address, every business location, and P.O. Box address.
- If the subcontractor or provider has corporate ownership, the tax identification number of the corporate owner(s).
- If the subcontractor or provider is an individual, date of birth and Social Security number.
- If the subcontractor or provider has a 5% ownership interest in any of its subcontractors, the tax identification number of the subcontractors.
- Whether any person with an ownership or control interest in the subcontractor or provider is related by marriage or blood as a spouse, parent, child, or sibling to any other person with an ownership or control interest in the subcontractor/provider.
- If the subcontractor or provider has a 5% ownership interest in any of its subcontractors, whether any person with an ownership or control interest in such subcontractors is related by

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marriage or blood as a spouse, parent, child, or sibling to any other person with an ownership or control interest in the subcontractor or provider.

- Whether any person with an ownership or control interest in the subcontractor/provider also has an ownership or control interest in any other Medicaid provider, in the state's fiscal provider, or in any managed care entity.

Upon request, SWH and its subcontractors shall furnish to EOHHS full and complete business transaction information as described in Section 4.0.6 of this document.

Within 35 days of a written request by EOHHS and/or the U.S. Department of Health and Human Services, SWH will furnish full and complete information to EOHHS, or the U.S. Department of Health and Human Services, as required by 42 CFR 455.105 regarding business transactions, including:

- Any sale or exchange or leasing of any property between SWH and such a party.
- Any furnishing for consideration of goods, services (including management services), or facilities between SWH and such a party but not including salaries paid to employees for services provided in the normal course of their employment.
- Any lending of money or other extension of credit between SWH and such a party.

4.0.4 SWH Providers and Employees – Exclusions, Debarment, and Termination

SWH is prohibited from paying with funds received under its contract with MassHealth for goods and services furnished by an excluded person, at the medical direction, or on the prescription of an excluded person.

SWH will monitor for excluded individuals and entities by:

- Screening provider and subcontractor individuals and entities with an ownership or control interest during the initial provider application, credentialing and re-credentialing processes and prior to entering into a contractual or other relationship where the individual or entity would benefit directly or indirectly from funds received under SWH's contract with MassHealth and payable by a federal health care program.
- Screening individuals during the initial provider application, credentialing and re-credentialing process and before entering into a contractual or other relationship where the individual would benefit directly or indirectly from funds received under SWH's contract with MassHealth or payable by a federal health care program.
- Screening the OIG-LEIE, SAM, State Medicaid agency exclusion on an ongoing basis for all Contractor and subcontractor individuals and entities with an ownership or control interest, individuals defined as affiliates, as defined in the Federal Acquisition Regulation, of a person described in paragraph (a)(1), and individuals that would benefit from funds received under SWH's contract with MassHealth for newly added excluded individuals and entities.

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SWH shall immediately report any discovered exclusion of an employee or contractor to the EOHHS Compliance Officer.

SWH shall not knowingly have a director, officer, partner, or person with beneficial ownership of more than five percent (5%) of SWH's equity who has been or who is affiliated with another person who has been debarred or suspended from participating in procurement activities.

SWH shall not have an employment, consulting, or any other agreement with a debarred or suspended person or entity for the provision of items or services that are significant and material to its contract with MassHealth.

SWH shall not employ or contract, directly or indirectly, with:

- Any individual or entity excluded from Medicaid or other federal health care program participation;
- Any individual or entity discharged or suspended from doing business with the MassHealth; or
- Any entity that has a contractual relationship (direct or indirect) with an individual convicted of certain crimes as described in Section 1128(b)(8) of the Social Security Act.

4.0.5 Review of Employees

SWH must perform the same screening of employees and administrative contractors as required by the contract. All Molina employees, including SWH employees, are checked against the federal LEIE as part of the hiring process. In addition, monthly review of the LEIE is done by a Molina vendor to identify employees whose status may have changed. The results of these reviews are reported to Molina monthly, whereby appropriate action will be taken as necessary.

4.0.6 Information Related to Business Transactions

SWH agrees to furnish to EOHHS full and complete business transaction information as follows:

- The ownership of any subcontractor with whom SWH or the subcontractor has had business transactions totaling more than $25,000 during the 12-month period ending on the date of this request; and
- Any significant business transactions between SWH or the subcontractor and any wholly owned supplier, or between the provider and any subcontractor, during the five-year period ending on the date of this request.

In accordance with 42 CFR 455.101, "significant business transactions" means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 or 5% of SWH's total operating expenses.

4.0.7 Information on Persons Convicted of Crimes

SWH agrees to investigate and disclose to MassHealth, at contract execution or renewal, and on request of MassHealth, the identity of any person who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XXI services program since the inception of those programs and who is an agent or person who has been delegated authority to obligate or act on behalf of SWH.

4.0.8 Monitoring Service Patterns

Data analysis is used to identify aberrant service patterns, potential areas of overutilization or underutilization, changes in provider behavior, and possible improper billing schemes. The goal of the data analysis process is to identify practices posing the greatest financial risk to the State of Massachusetts Medicaid funds, which can in turn result in poor quality of care for members.

Data analysis processes provide a comparative data review on a provider, member, and global basis. With the assistance of resources made available to the SIU, comparative data on how a provider varies from other providers in the same specialty type and geographic area can be composed. Data analysis has the ability to:

- Establish a baseline to enable the SIU to recognize unusual trends, changes in utilization, and/or schemes to inappropriately maximize reimbursement.
- Identifies specific provider and common billing patterns.
- Identifies high volume or high cost services.
- Identifies provider and patient utilization patterns.
- Identifies provider referral patterns.

Data analysis is a tool for identifying potential errors along with fraud, waste, and abuse through analytical methodologies. The data analysis process uses claim information and other related data to identify potential errors, fraud, waste, and abuse for individual providers, members, or the aggregate.

4.0.9 Data Matching, Trending, and Statistical Analysis

Data matching, trending, and statistical analysis are conducted on a continual basis for each area defined:

- Peer-to-peer provider comparisons by cost of service.
- Peer-to-peer provider comparisons by service type within a geographic area.
- Peer-to-peer provider comparisons by diagnosis types.
- Member-to-member comparisons by cost of services by service type.
- Member-to-member comparisons by quantity of services by service type.
- Comparison analysis of procedures, which are commonly over-abused.
- Comparison analysis of common diagnoses by population.

4.0.10 Claims Data Analysis

SWH has an effective pre-payment and post-payment review process, including but not limited to data analysis, claims, and other system edits, and auditing of participating providers.

SWH uses data analysis that regularly screen for anomalies. The following is not an all-inclusive list:

- Application of CMS CCI rules identifying illogical pairings of codes
- Rules identifying age diagnosis conflicts, once in a lifetime procedure, gender specific treatments
- Assessments of highly abuses lab codes and lab provider billing patterns
- Unbundling rules identifies providers who are billing component parts of a global laboratory panel, rather than billing the stand-alone global lab panel
- Diagnosis upcoding and multiple codes inconsistent to CPTs billed.
- Spike activity assessments rules evaluating providers billing behavior for volume changes
- Modifier assessment rules for improper usage of code modifiers
- Providers' changing billing patterns and amounts for Current Procedural Terminology (CPT) codes that may indicate the provider may be fishing for maximum payment amount (improper billing).
- Durable Medical Equipment (DME) rental costs exceed the actual cost of the item.
- Excessive referrals to specific providers.
- Frequency of visits based on diagnosis.
- Provider frequently uses unusual codes.
- Services with extended lengths of time.
- Services that reflect the most variation and frequency for a provider.

4.0.11 Use of Claims Edits

Each claim transaction is processed through a series of two system edits and rules to isolate potential fraud, waste, and abuse. Claim transaction edits and rules determine and report incorrect or abusive billing codes and include, but are not limited to:

- Unbundling – separate services that should be combined into one CPT code.
- Double coding – charging separately for various steps in a procedure.
- Incidental billing – charging for services that are considered to be a component of a more comprehensive procedure or mutually exclusive to another service.
- Evaluation and management code churning – evaluation and management visits on the same day.
- Global fee screening – verified services that are part of a global surgical procedure (post-operative procedures)
- Duplicate billing on same or separate claims with same date of service.

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- Multiple like services provided on same day.
- Primary care services performed by specialty care physician.
- Service inconsistent to sex or age of member.
- Primary and assistant surgeon services billed by same provider.
- New vs. established patient.
- Pathology bundling/unbundling.
- Validate modifiers by procedure.
- Multiple procedure reduction rules.
- Professional and technical procedures – double billing.
- Claims paid for an amount greater than billed amount.

4.0.12 Routine Validation of Data

SWH routinely validates its data through the use of retrospective claims payment review. In addition to validating the data, retrospective analysis also identifies claim errors, inconsistencies, as well as fraud, waste, and abuse for claims already paid. Routine validation will also review for instances of providers who bill for services not rendered.

4.0.13 Claims Review

In addition to the SIU, SWH also have different departments conducing claims reviews and different audits to help mitigate risks associated with overpayment of claims. Claims reviews may also be supported by the claims and payment integrity departments.

SWH also has teams of coders that conduct coding reviews for providers that are part of the SWH network. Some of these reviews are conducted for high paid providers based on claims utilization.

4.0.14 Prescription Drug Utilization Management Program

SWH has processes in place to comply with all applicable federal and state laws, rules, and regulations. (Attachment II, Section XV.A.1.; Attachment II, Section XV.A.2.; Attachment II, Section VIII.C.5.a.) Section 1004 of the federal SUPPORT Act (Public Law No: 115-271) requires Medicaid programs to operate Drug Utilization Review (DUR) programs that comply with SUPPORT Act requirements.

SWH Prescription Drug Utilization Management Program includes limitations and automated claims review processes for prior authorization or retrospective review of the following:

1. Early refills, duplicate fills, max days' supply, max quantity, max daily morphine milligram equivalent limitations, step therapy, and concurrent drug use limitations on opioids

2. Automated claims review process and reporting which identifies if members exceed opioid limitations and/or meet criteria for pharmacy lock- in

SWH may assign an enrollee to the SWH Pharmacy Lock-in program if the enrollee has demonstrated one of the following:

1. Obtained three or more controlled substance prescriptions from three or more pharmacies written by three or more different prescribers within 180 days.
2. Been convicted of fraud through the unauthorized sale or transfer of a pharmaceutical product funded by Medicaid.
3. Utilized more than ten different controlled substance prescribers in 90 days.
4. Obtained two or more controlled substance prescriptions written by two or more different prescribers who have utilized two or more pharmacies within 180 days AND have a documented diagnosis of narcotic poisoning or drug abuse within the last 365 days.
5. Violated a pain management agreement/contract with their prescriber
6. Exceptions include enrollees diagnosed with sickle cell disease or cancer, enrollees residing in institutionalized settings, and enrollees who are dually enrolled in Medicare and Medicaid.

In addition, SWH has internal controls and procedures in place in compliance with Section 1004 of the SUPPORT ACT that are designed to identify potential fraud, waste, or abuse of controlled substances by enrollees, providers, and pharmacies.

4.0.15 Member Services

Member Services employees are responsible for responding to questions and concerns from members. Members may provide Member Services employees with information regarding suspected provider or member health care fraud, waste, and abuse. On receipt of such information, the Member Services employee will document the information and report the allegation to the SIU and/or Compliance.

4.0.16 Utilization Management (UM)

UM employees are responsible for processing authorization requests for referrals for services from providers and facilities. Occurrences or trends related to the potential misuse or fraudulent use of services may come to their attention. When an UM employee suspects an instance of health care fraud, waste, or abuse, he/she shall document the instance and report it to the SIU and/ or Compliance.

In addition, Utilization Management will conduct quality assurance and utilization review of hospital providers.

4.0.17 Member Verification of Services

SWH is required to verify that services billed by providers were actually provided to enrollees. To this end, on a quarterly basis a statistically valid sample size of the health plans membership is mailed a Service Verification Claim Summary form.

4.0.18 Embezzlement and Theft

On an ongoing basis, SWH uses several processes to detect suspected health care-related fraud, waste, and abuse by its providers, members, employees and delegated entities. SWH works with its Human Resources department in:

- Verifying the accuracy of employment applications.
- Identifying potential conflicts of interest.
- Reviewing additional data sources as needed.

4.0.19 Under/Overutilization of Services

Annually, SWH monitors its prior authorization procedures to ensure that they do not unreasonably limit a member's access to Medicaid services. SWH also annually reviews the procedures its providers follow in appealing a SWH denial of a prior authorization request. This review assists in ensuring that SWH's process does not unreasonably limit a member's access to Medicaid covered services. In addition, on an ongoing basis, SWH reviews and monitors its service denials and utilization in order to identify services that may be under and over utilized.

Section 5

5.0 Audits and Investigation of Potential Fraud, Waste, and Abuse

The SIU conducts objective audits and investigations related to health care fraud, waste, and abuse. The purpose of an investigation is to gather evidence related to an allegation to determine the likelihood that potential fraud, waste, or abuse may have occurred. An audit may originate from external or internal leads or from data mining activities. The purpose of conducting proactive audits is to obtain reasonable assurance that providers are billing for services that are rendered and that those services meet the criteria for such payment.

PROPRIETARY AND CONFIDENTIAL

In an effort to reduce and deter fraud, waste, and abuse, the SIU primarily conducts investigations involving allegations against providers or members who may potentially be engaged in illegal activity. The type of allegation determines the scope of the review.

5.0.1 Provider Investigation

The following information shows the steps involved in conducting a provider investigation. SWH will obtain approval from MassHealth prior to the initiation of any investigation; additionally, SWH will obtain approval from MassHealth prior to issuing findings of the completed investigation, including any overpayment identified.

5.0.1.1 Preliminary Investigation

When a report or identification of suspected provider fraud, waste, and abuse is communicated to the SIU, a preliminary investigation is initiated to collect relevant data and evaluate the circumstances of the allegation.

The preliminary investigation may include, but is not limited to, the following steps:

A. Determine if any previous reports of incidences of suspected waste, abuse, or fraud have been reported on the suspected provider, or if any previous investigations have been conducted on the provider.

B. Determine if the provider in question has ever received educational training with regard to the allegation for which the provider is being investigated.

C. Review the provider's billing and claim submission pattern to determine if there is any suspicious activity.

D. Review the provider's payment history to determine if there is any suspicious activity

E. Review of the policy and procedures for the program type in question to determine if what is alleged is a violation

If during the preliminary investigation, it is determined the case was based on a misunderstanding between the complainant and the suspect of the alleged fraud, or there was a claims processing/clerical error, or other rational explanation based on fact, SWH will document the findings of the preliminary review and close the investigation.

5.0.1.2 Extensive Investigation

This review is only initiated after MassHealth gives clearance to the SIU to contact the provider and initiate an audit or investigation.

A. If the preliminary investigation by the SIU determines the provider has shown suspicious activity indicating possible fraud, waste, or abuse, a sample of the provider's claims related to the suspected waste, abuse or fraud are selected for review.

B. Once the sample to be reviewed is selected, medical records[2] and encounter data are requested.

C. The requested medical records and encounter data are reviewed. As part of this review, utilization and quality of care are assessed, sufficiency of the service data is validated, and the encounter data is reviewed for accuracy. Records are assessed for altering, falsification, and inappropriate destruction. Additionally, if the content of the records received is not sufficient to determine if fraud, waste, and abuse has occurred, then additional records may be requested as necessary to effectively conduct a review.

Based on this information received, a medical and/or coding audit of the medical records against encounter data will commence.

5.0.1.3 Additional Record Request (as Appropriate)

The SIU may request records from supporting providers to verify continuity in information for service procedures and for quality of care. If necessary, for a complete and accurate audit, other records may be requested and reviewed. These include, but are not limited to:

- Lab results.
- Imaging and radiology results.
- Superbills used to input into the provider's accounting system what was rendered by the provider.
- Accounting records from the provider's billing system.
- Supplier's invoices.
- DME delivery records.
- Member inpatient charts.
- Detailed supply listings.
- Documents and agreements between parties being investigated.
- Hospital discharge summaries and transfer forms.
- Provider orders and progress notes describing the member's response to treatment and his/her physical/mental status.
- Nursing and rehabilitation therapy notes.
- Treatment, flow charts, vital sign records, weight charts, and medication records.

[2] Molina does not reimburse providers for copies of medical record documentation related to a fraud, waste, and abuse investigation.

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5.0.1.4 Extensive Investigation – Provider's Refusal to Provide Medical Record Documentation

Failure of the provider to supply the records requested by SWH will result in the provider being reported to MassHealth and/or MFCU as refusing to supply records upon request. The SIU will seek overpayment recovery in these situations as allowed by MassHealth and/or MFCU.

5.0.1.5 Extensive Investigation – Records Review Medical

In order to validate the sufficiency of delivery data and to assess utilization in complex cases, a medical officer or other medical professional may be engaged to oversee coding and billing audits conducted by the SIU. The reviewing medical officer or other medical professional shall review the records for correctness of diagnosis and medical care, proper utilization of services, quality of care, and billing.

It should also be noted if a quality-of-care issue is identified at any point during the investigative process, it will be immediately reported to the health plan's Quality Improvement department for review.

5.0.1.6 Suspected Fraud Referral

At any time during an audit, if fraud is suspected, the SIU will pause the audit, cease contact with the provider, and submit a fraud referral to MassHealth. The SIU follows this process:

- To submit a fraud referral: E-mail MassHealth Compliance (Joan Senatore) with cc to the applicable MassHealth Contract Manager.
- MassHealth will review the fraud referral and upon a determination of a credible allegation of fraud, make a referral to MFCU.
- If the referral does not rise to the level of a credible allegation fraud, MassHealth will inform SWH that it may proceed with the audit.
- If MassHealth refers a credible allegation of fraud to the MFCU and the MFCU accepts the referral, MassHealth will inform SWH that the referral has been accepted and provide additional information on how to proceed.

5.0.2 Member Investigation

The following information shows the steps involved in conducting a member investigation.

5.0.2.1 Preliminary Investigation (Member)

When a report or identification of suspected member fraud, waste, and abuse is communicated to the SIU, an investigation is initiated to collect relevant data and evaluate the circumstances of the allegation.

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The preliminary investigation includes, but is not limited to, the following steps:

A. Determine if any previous reports of incidences of suspected waste, abuse, or fraud have been reported on the member, or if any previous investigations have been conducted on the member

B. Review the member's billing and claim history patterns to determine if there is any suspicious activity.

C. Consider analysis of pharmacy claim data submitted by providers for the suspected member to determine possible abuse of controlled or non-controlled medications as applicable.

5.0.2.2 Extensive Investigation (Member)

The following process is followed:

A. The SIU identifies all providers and claims that are subject to the member's investigation.

B. The SIU sends a request for medical records to providers.

This information will be used to validate services and to determine the likelihood that fraud, waste, or abuse may have occurred.

5.0.3 Reporting to Appropriate Government Agencies

5.0.3.1 External Referrals to EOHHS and/or Massachusetts MFCU

SWH will report no later than five business days to EOHHS, in accordance with all other Contract requirements, all overpayments (including capitation payments or other payments in excess of amounts) identified and/or recovered, specifying those overpayments attributable to potential fraud;

SWH will report promptly to EOHHS, in accordance with all other Contract requirements, when it receives information about an Enrollee's circumstances that may affect the Enrollee's MassHealth eligibility

SWH will report no later than five business days to EOHHS, in accordance with all other Contract requirements, when it receives information about a Provider's circumstances that may affect its ability to participate in SWH's network or in MassHealth

SWH will report within five business days to EOHHS, in accordance with all other Contract requirements, any potential fraud, abuse, or waste that SWH identifies or, in accordance with EOHHS policies, directly to the Medicaid Fraud Unit

PROPRIETARY AND CONFIDENTIAL

SWH will first notify EOHHS and receive its approval prior to initiating contact with a Provider suspected of Fraud about the suspected activity

Upon a complaint of Fraud, Waste or Abuse from any source or upon identifying any questionable practices, SWH will report the matter in writing to EOHHS within five business days

SWH will notify EOHHS within two business days after contact by the Medicaid Fraud Division (MFD), the Bureau of Special Investigations (BSI) or any other investigative authorities conducting Fraud and Abuse investigations, unless specifically directed by the investigative authorities not to notify EOHHS.

SWH will notify EOHHS within one business day of any voluntary Provider disclosures resulting in receipt of overpayments in excess of $25,000, even if there is no suspicion of fraudulent activity

5.0.3.2 Reporting Requirements

SWH is responsible for submitting program integrity notifications and related reports as described in the following sections. All program integrity notifications and reports must be sent to EOHHS unless otherwise specified.

5.0.3.2.1 Quarterly Reports

On a quarterly basis, SWH will submit the following to EOHHS:

- A fraud and abuse report according to the format specified by EOHHS, and submit ad hoc reports as needed, or as requested by EOHHS in accordance with **Appendix D** of the Restated SCO Contract.

5.0.3.2.2 Annual Report

On an annual basis (unless otherwise directed), SWH will submit the following report to EOHHS:

- SWH will have the CEO or CFO certify in writing on an annual basis to EOHHS, using the appropriate Appendix D certification checklist, that after a diligent inquiry, to the best of his/her knowledge and belief, the Contractor is in compliance with this Contract and has not been made aware of any instances of Fraud and Abuse in any program covered by this Contract, other than those that have been reported by the Contractor in writing to EOHHS.
- Report annually to EOHHS, in a form and format specified by EOHHS all recoveries of overpayments in accordance with 42 CFR 438.608
- Annual Fraud and Abuse reports as specified in Appendix D of the Restated SCO Contract

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5.0.5 Participation in MassHealth MCE Quarterly Meetings/ Program Integrity Forums

SWH shall participate in MCE-specific quarterly meetings with MassHealth and the AGO-Medicaid Fraud Division (MFD). Discussions at these meetings shall include but not be limited to shared allegation cases, excluded providers, contractual obligations, training, MCE Annual Program Integrity Report, referrals to MassHealth, open discussions, surveys and monitoring. SWH shall also participate in ad-hoc meetings as they are scheduled by MassHealth and/or the MFD.

5.0.6 Risk Assessment

The SIU has established a process for assessing the risk for FWA on a continuous basis. The process includes an annual identification, evaluation and assessment of risks utilizing various sources of information including the Department of Health and Human Services Office of Inspector General (HHS-OIG) Annual Work Plan, state-specific fraud, waste and abuse activity reports, internally identified areas of risk, risks identified by the Federal Bureau of Investigations (FBI) or Federal Office of Personnel Management (OPM), leads and schemes learned at information sharing events, local fraud task force meetings, published news articles, results of data analysis and data mining, and other sources. The SIU also identifies potential areas of risk on an ongoing basis through monitoring and information sharing. The assessment process considers compensating controls, exposure, impact, and likelihood of the risk and helps determine the content and priorities for the work plan.

All risks included in the risk assessment are given a final score of Critical, High, Medium, or Low respectively. The SIU then develops the annual audit plan by giving priority to the risks that have a higher score.

Section 6

6.0 Maintaining the Confidentiality of Member Information and Maintenance of Records

The SIU maintains strict confidentiality of all reports, records, and investigations of suspected fraud, waste, and abuse. All reports of fraud, waste, and abuse are maintained in the SIU Case Management System. The Case Management System records the subject of the report, the source, the allegation, the date the allegation was received, the member's or provider's identification number, as applicable, and the status of the investigation. This information is disseminated only to designated personnel who have a need for access. These personnel may include the SIU

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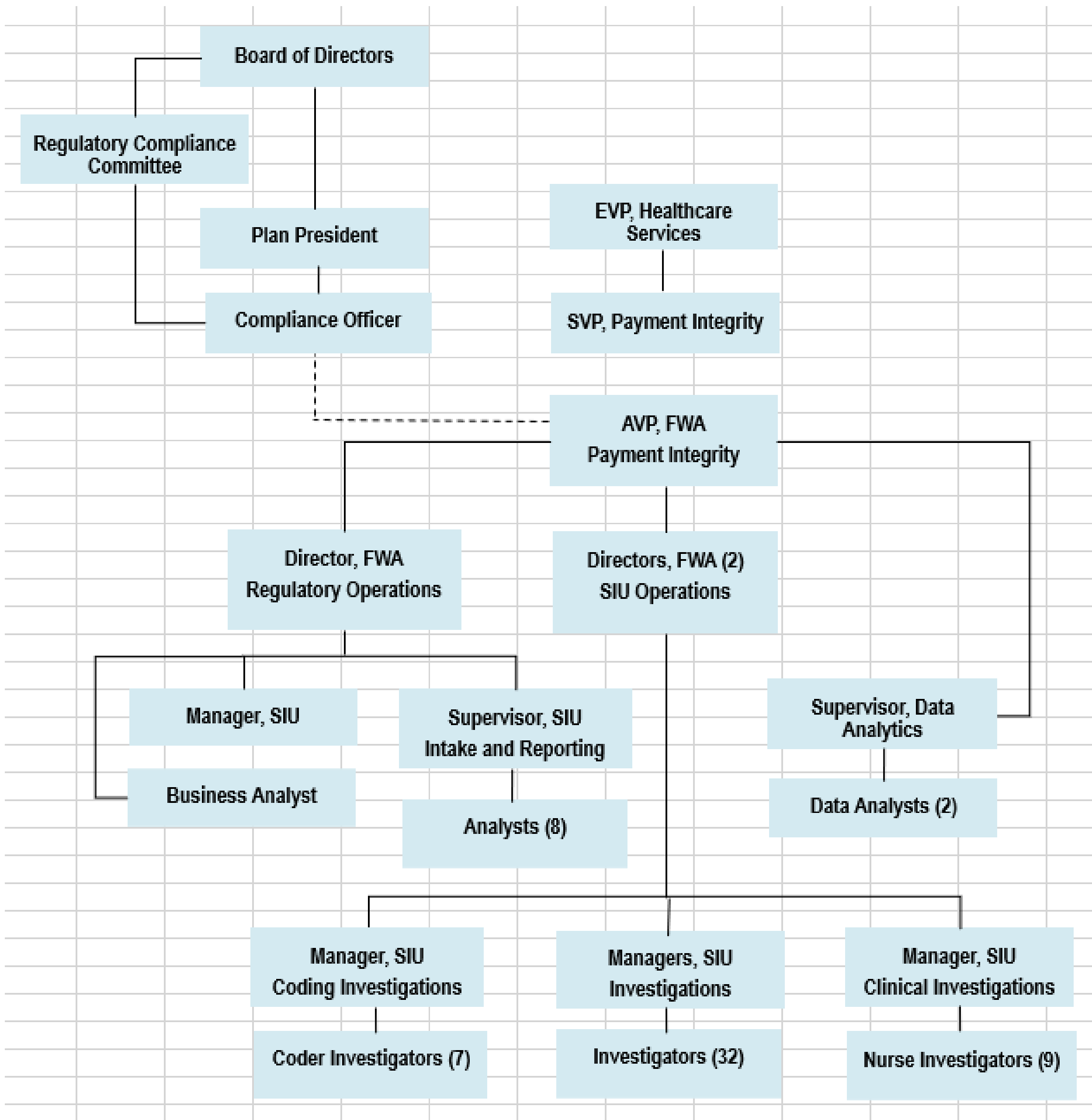
Members, legal staff, and designated management staff. Confidentiality abides by state and federal law.

SWH will retain records obtained as the result of an investigation conducted by the SIU for a minimum period of 10 years or until all audit questions, appealed hearings, investigations, or court cases are resolved.

ATTACHMENTS

ATTACHMENT A

Special Investigation Unit



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ATTACHMENT B

Molina Healthcare conducts its business with an unwavering commitment to compliant and ethical conduct. It is not just foundational to our operations, it is also a commitment that I personally make to our members, state partners, providers, employees, and all other stakeholders.
This Code of Business Conduct and Ethics provides a roadmap to that commitment. It helps direct our behavior and decisions, from our front-line employees to our most senior leadership. Each year we require that all our employees and our board members review it and acknowledge their commitment to the principles it contains. If anyone – employees, members, providers, contactors, board members – perceives a violation, they are required to report it. This constant vigilance allows us to build on the compliant and ethical conduct that is a hallmark of Molina Healthcare.
We must keep the Code forefront in our minds every day. By doing so, we will successfully meet our commitment to ensure that every interaction we have and decision we make is both compliant and ethical.
Sincerely,
Joe

CODE OF BUSINESS CONDUCT AND ETHICS

This Code of Business Conduct and Ethics (Code) has been approved by the Board of Directors of Molina Healthcare, Inc. and its affiliates (Molina) and is applicable to all employees, directors, officers, and subcontractors of Molina. Its purpose is to guide Molina's affairs and detail the way Molina conducts business. It is the absolute expectation that we conduct business in accordance with applicable laws, rules, and contract requirements, as well as ethical business practices and professional practices. Whenever the Code mentions an "employee," it includes an employee, director, or officer of Molina. Further, whenever the Code refers to a "subcontractor," it may refer to a subcontractor, vendor, or other stakeholder of Molina.
All employees – as a condition of their employment – are required to acknowledge their receipt and understanding of this Code when they are hired, and then annually thereafter. Additionally, employees are required to complete a conflict of interest disclosure when they are hired, annually, and at any time a potential conflict of interest may arise. All employees and subcontractors must immediately report good-faith and reasonable suspicions related to a potential violation of any section of the Code.
Anyone, regardless of title or position, whom Molina determines has engaged in behavior that violates this Code may be subject to disciplinary action, including termination. Additionally, violating this Code may result in civil liability and/or criminal prosecution. Any employee who authorizes or knowingly permits another employee to engage in a violation of this Code may also be subject to disciplinary action, including termination.

Molina Mission, Vision, and Values

The principles contained in our Code help ensure that each of our actions and decisions are

compliant and ethical. In addition, the principles in our Code help to support successful alignment with Molina's Mission Statement, Vision, and Values.

Mission Statement
We improve the health and lives of our members by delivering high-quality health care.

Vision
We will distinguish ourselves as the low cost, most effective, and reliable health plan delivering government-sponsored care.

Values

- Integrity always
- Absolute accountability
- Supportive teamwork
- Honest and open communication
- Member and community focused

Integrity and Ethics
Our success depends on our ability to authentically and genuinely serve our customers (members, providers, state partners, regulators, elected officials, community organizations, coworkers, and other stakeholders) in an ethical and compliant manner. This requires that all Molina employees and subcontractors work with the highest degree of integrity, follow the rules, and do the right thing. This Code can be used as an ethical compass.
Our ethical principles are the values that set the ground rules for the way we perform our jobs. Employees and subcontractors are expected to be honest, respectful, fair, and compassionate. Not only must we follow all legal requirements, we must also adhere to ethical principles when performing work on behalf of Molina.

Accountability
Every employee and subcontractor must comply with the standards established in this Code and follow it at all times. Any perceived violation, misconduct, and/or noncompliance including fraud, waste, and abuse must be reported immediately to a manager, compliance officer, or via the Alert Line by calling (866) 606-3889 or filing a report online at
https://molinahealthcare.AlertLine.com.
If there is ever any doubt in how this Code applies or to whom it may apply, employees are encouraged to contact their immediate supervisor, manager, human resources, local compliance officer, or Molina's legal department. Subcontractors should reach out to their designated Molina contact.

Employee Rights, Responsibilities, and Duties

Duty to Report
Molina's employees and subcontractors are our first line of defense in addressing any suspected wrongdoing. This means that it is our duty to report suspected noncompliance with this Code for investigation and correction. Violations of this Code, regardless of whether they are observed during or outside of regular work hours, must be reported as soon as practical to

an immediate supervisor, manager, human resources, compliance officer, or the legal department. The employee or subcontractor may also report violations to another member of Molina's leadership team, chief compliance officer, or the Board of Directors. Employees and subcontractors must not allow noncompliant or risky issues or behavior to persist without reporting their concerns.

It is the right of every employee or subcontractor to report or make an inquiry regarding possible Code violations without being subjected to retaliation or risk of losing job or contractor status.

Retaliation

Molina does not tolerate retaliation for reports made in good faith. Retaliation is revenge, reprisal, retribution, or 'getting back' at someone for making a good-faith reporting of observed or perceived misconduct. Good faith reports are made to the best of a person's ability, to be true and made without ill will or personal benefit. For each inquiry or report, Molina will make a reasonable effort to protect the identity of the reporter. However, a reporter's identity may need to be disclosed if, for example, the matter becomes part of a legal proceeding or if law enforcement is involved.

Retaliation could include: being fired, demoted, or laid off due to the report; receiving a change in salary or scheduled hours; a change in job responsibilities or assignment, relocation, or being transferred; forced or 'suggested' resignation; injury to reputation, property or person; being left out of decision-making and/or meetings; abuse, harassment, and/or humiliation from supervisors and coworkers; promotion restrictions; negative or targeted coaching or evaluations and heavy-handed monitoring that peers do not experience without another reason. Retaliation can occur in many different ways, none of which are tolerated by Molina. It is everyone's job to report potential noncompliance or unethical dealings for investigation. We do not 'get back' at anyone for doing their job.

Audits and Investigations

All employees and subcontractors must be honest and forthright in their work and interactions with their coworkers and Molina's stakeholders. All employees must provide all information requested by Molina's internal and external auditors, legal representatives, human resources partners, and/or compliance officers and staff.

Employees must notify Molina's legal department if they receive any of the following: a request to appear or testify before a grand jury, regulatory body, or government agency; notification that a regulatory body or government agency has started a Molina-related investigation; notification of an inspection or interview by a regulatory body or government agency; or notification from a regulatory body or government agency threatening fines, penalties, or other punitive actions.

Fair Treatment

Employees and subcontractors must be respectful to our employees, members, providers, regulators, community partners, and competitors. No employee or subcontractor should take unfair advantage of anyone through manipulation, suppression of information, abuse of access to privileged information for personal gain, misrepresentation of relevant facts, or any other

unfair or unethical dealing or practice. Failing to meet this standard may result in disciplinary action, including termination.

Responsibilities of Executives and Management

Molina has high expectations of its leaders. These requirements apply to Molina's executive and management teams, including the Board of Directors, the chief executive officer, and other senior leaders (executives). Like all employees, Molina's executive and management teams are required to observe the highest standards of ethical business conduct, which means a strict adherence to this Code and the letter and spirit of the following statement:

Each executive will always act honestly and ethically, including the ethical handling of actual or apparent conflicts of interest between personal and professional relationships. "Actual or apparent conflict of interest" is broadly construed and includes, for example, direct conflicts, indirect conflicts, potential conflicts, apparent conflicts, and any other personal, business, or professional relationship or dealing that has a reasonable possibility of creating the appearance of impropriety or a conflict of interest.

Each executive should make every effort to, within his or her areas of responsibility, provide full, fair, accurate, timely, and understandable disclosure in reports and documents that the Company files with or submits to regulatory agencies. In addition, each executive must provide full, fair, accurate, and understandable information whenever communicating with Molina's stockholders or the general public.

Conflict of Interest

Conflicts of interest arise when loyalty is divided between Molina's best interest and our own personal interests. While there is nothing wrong with having multiple interests, the issue is when there are ethical complications that cause us to act on the basis of our own personal interest rather than in Molina's best interest. Every employee and subcontractor has a duty to avoid business, financial, or other direct or indirect interests or relationships that conflict with Molina's interests. Examples of a conflict of interest may include: certain personal relationships; involvement in community organizations with which Molina collaborates; acceptance of gifts, hospitality, and rewards from contractors, suppliers, organizations, and individuals that make it difficult to avoid an obligation.

If an employee or a subcontractor wishes to engage in a transaction or activity that may potentially be in conflict with Molina's interest, the employee or subcontractor must disclose this information in writing as outlined in **Molina's Conflict of Interest Policy**. The disclosure will be reviewed and a determination and/or recommendation for addressing the conflict will be made.

Gifts and Bribes

PROPRIETARY AND CONFIDENTIAL

Gifts or rewards must be accepted with discretion, without affecting one's judgment or decision-making. It is Molina's policy to exercise discretion in offering gifts or hospitality to members, suppliers, or any other party, and in full compliance with our contractual, statutory, and regulatory requirements. Employees and subcontractors can request guidance from Molina's legal department when presented with any gift or reward (goods, food/beverages, event invitations or tickets, etc.) that exceeds permissible values set forth in any Molina policies then in effect addressing gifts or rewards (i.e. employee handbook, conflict of interest policy).

Antitrust and Competition

Antitrust laws are complex and cover a broad range of conduct that may be illegal. In general, antitrust law prohibits making agreements or sharing information with competitors on items including product plans, pricing, marketing strategies, and profit/profit margins. Molina complies with all applicable antitrust laws and requires that its employees do the same. If an employee intends to participate in a trade association or serve on a standards setting body related to our industry, the employee must avoid sharing any confidential or sensitive pricing or other non-public information with our competitors.

If an employee has any questions, they should consult the legal department or compliance department prior to sharing information or communicating with competitors, regulatory agencies, or other third parties, including any non-Molina attorneys.

Financial Controls

Molina maintains strict standards of internal accounting controls. Our chief financial officer ensures that these internal controls remain effective and comply with the highest industry standards.

Employees commit to keeping complete and accurate company records. Employees cannot create false or artificial accounting records. To ensure all records are correct, requests for payment must be accompanied by supporting documentation.

All Molina funds, payments, and transactions must be recorded in accordance with U.S. Generally Accepted Accounting Principles (GAAP). Our records must be complete and accurate, and fully reflect our financial activities and transactions, including claim payments, medical billing documentation, expenses, purchases, account receivables and sales. This information is required to be reported to governmental agencies and shareholders, so it is imperative that we follow GAAP and other applicable laws.

Although intra-company transactions, such as loans to employees from financial institutions that do business with Molina, are permissible, these transactions must be priced at a "fair market value." If that market pricing is unavailable, prices will be based on cost and reasonable profit data.

The Foreign Corrupt Practices Act (FCPA) prohibits bribery of a foreign official and also requires U.S. companies to maintain internal accounting controls and keep books and records that accurately reflect all transactions. The FCPA makes it a crime for Molina or its directors, officers, employees, or agents to directly or indirectly offer or pay a bribe or "anything of value" to a

foreign official, regardless of rank or position. The FCPA forbids not only monetary bribes but also bribes of anything of value, such as stock, entertainment, gifts, discounts on products and services not readily available to the public, offer of employment, assumption or forgiveness of debt, payment of travel expenses, and personal favors. Molina is committed to complying with all restrictions imposed by the FCPA. Employees and subcontractors must report all good-faith and reasonable suspicions related to activities in potential violation of the FCPA.

Anti-Money Laundering

Money laundering involves the concealment of the origins of money gained through illegal activity, including drug transactions, bribery, terrorism, or fraud and is a crime that can result in fines and imprisonment. Molina complies fully with anti-money laundering laws and regulations. Molina can be severely damaged by failing to detect transactions or relationships that put Molina and our members at risk. Employees and subcontractors are expected to be familiar with Molina's programs to detect, prevent, and report suspected money laundering activities, including evidence of criminal activity by a member or counterparty, transaction structures or forms of payment that lack commercial justification, or other suspicious activity. Employees and subcontractors must report all good-faith and reasonable suspicions related to potential money laundering activities.

Compliance and Fraud, Waste and Abuse (FWA)

Molina knows the importance of protecting and strengthening our members' healthcare resources, and as such, we are dedicated to preventing fraud, waste, and abuse in government programs and our industry. Molina operates Compliance and FWA programs designed to prevent and reduce fraud, waste and abuse among members, providers, employees, and subcontractors.

Under the False Claims Act (FCA), individuals and entities cannot knowingly submit a false or fraudulent claim for payment of United States Government Funds. In addition to the traditionally thought of provider or member fraud, the FCA applies to claims made for payment to Medicaid, Medicare, and other government sponsored healthcare programs by healthcare companies like Molina. Potential fines for violating the FCA include:

1. Up to three times the amount of the payment made on each false claim
2. Additional civil penalties for each false claim
3. Payment of the cost of the civil action by the entity or individual that submitted the false claim

If found liable under the FCA, the company or individual may also be excluded or suspended from participating in all federal healthcare programs. Individuals may also be required to serve time in jail.

We are stewards of public funds. Employees and subcontractors have an obligation to report any actual or suspected violation of the FCA, and suspected or actual misuse or illegal use of government funds. To encourage its employees to come forward and report incidents of false claims, Molina reminds all employees of their "whistleblower" protections under the FCA which prohibit retaliation:

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Any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by his or her employer because of lawful acts done by the employee on behalf of his employer or others in furtherance of an action under this section, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under this section, shall be entitled to all relief necessary to make the employee whole." (31 U.S.C. Sec. 3730(h))

Molina employees and subcontractors also may not use or disclose nonpublic or inside information for personal financial benefit or the financial benefit of family, friends or others. Each employee is subject to our **Insider Trading Policy**, which explains the laws and policies respecting transactions involving Molina's securities and the securities of other companies.

Privacy and Security of Information

Employees and subcontractors must protect the privacy and security of Molina's confidential information and information about Molina members and follow all applicable rules and regulations associated with the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), and applicable state privacy and cybersecurity laws.

• Any unauthorized use or disclosure of protected health information must be immediately reported to Molina's privacy official at (866) 665-4629 or **HIPAAMailbox@Molinahealthcare.com**.

• Any cybersecurity event, such as any act or attempt, successful or unsuccessful, to gain unauthorized access to, disrupt or misuse, Molina's information systems or confidential information, including protected health information or personally identifying information, must be immediately reported to Molina's chief information security officer at (844) 821-1942 or **CyberIncidentReporting@molinahealthcare.com**.

Protecting Confidential Information

All employees and subcontractors are expected to protect Molina's confidential and proprietary information, including Molina's trade secrets. Molina's confidential and proprietary information includes: business plans, financial reports, marketing plans, know-how and processes, personnel and salary information, member information, and various materials associated with our services. Employees must keep Molina's proprietary information confidential, unless they are authorized to disclose such details. Employees must also refrain from disclosing any proprietary information of our competitors.

Protecting Molina's Assets

Molina has a variety of assets, many of them very valuable. They include physical items as well as proprietary or private information that can also include intellectual property and confidential

data. Protecting all these assets against loss, theft, and misuse is very important. Examples of Molina assets include:

- Molina credit cards, cash and checks
- Buildings and fixtures
- Computers, hardware, and software
- Office supplies
- Fax and copy machines
- Documents, information/data, and records
- Telephones and voicemail systems
- Email, intranet, and internet access

Each employee or subcontractor is responsible for protecting Molina's property assigned to him or her and for helping to protect Molina's assets in general. Upon termination of employment or contractual relationship with Molina, employees and subcontractors must immediately return any Molina assets assigned to them.
Employees and subcontractors must also report all good-faith and reasonable suspicions related to potential instances where Molina's assets are vulnerable or misused. If you see any situation that could lead to the loss, misuse, or theft of Molina's assets, you must report this immediately to your supervisor, manager, another member of the leadership team, local compliance officer, or the chief compliance officer.

What is the difference between proprietary information and confidential information?
Proprietary information is any information that gives Molina a competitive advantage. Confidential information is meant to be kept secret or held within a small number of specific people.

Proprietary information is usually confidential. This is information that is not shared with people outside of Molina. It includes, among other things, business, financial, marketing plans associated with Molina's services, know-how and processes, business plans, personnel and salary information, patient information, and copyright material connected with our services. Employees and subcontractors must not use or disclose Molina's proprietary information except as approved by Molina. Similarly, employees and subcontractors are prohibited from stealing the confidential or proprietary information of Molina's competitors.
Unintended disclosure of proprietary or confidential information by employees and subcontractors can also harm Molina's interest. You should not discuss confidential information, even with approved people within Molina, if you are in the general presence of others, i.e. at a trade show, reception, or in an airplane. Please keep in mind that harmful disclosure can start with the smallest leak, since bits of information may be pieced together with fragments from other sources to form a complete picture. Additionally, you should not discuss this information with individuals within Molina who are not approved to receive such information.

If questioned by someone outside Molina about Molina's confidential information, do not answer unless you are certain you are approved to do so. If you do not have approval to disclose such information, refer the person to the appropriate Molina officer.

If you retire or leave Molina, you may not disclose or misuse Molina's confidential information, and you must return any such information to Molina. Furthermore, Molina's ownership of intellectual property that you created while an employee continues after you leave Molina. The requirements to not share confidential and proprietary includes posting this sort of information to social media.

Compliance with Laws Governing our Business

We are part of a highly regulated industry and therefore laws, regulations, and contractual obligations govern nearly every aspect of our business. All employees and subcontractor are held accountable to Molina's Compliance Plan with respect to laws and regulations governing our business. It is imperative to comply with the standards of this Code and immediately report any perceived violations. Employees and subcontractors must immediately report all good-faith and reasonable suspicions related to a potential violation of any laws, regulations or contractual obligations related to our business.
If an Employee or Subcontractor has any questions pertaining to this Code, the Compliance Plan, policies and procedures, and/or applicable federal and state laws, they are encouraged to contact the following:

- Employees must contact the compliance department/chief compliance officer or legal department/chief legal officer, call the Alert Line at (866) 606-3889, or file a report online at https://molinahealthcare.AlertLine.com and must act in accordance with the guidance/advice they receive.
- Subcontractors are encouraged to contact their designated Molina contact or relevant compliance officer/chief compliance officer.

Speaking Out

Because our work involves government programs, our Company is very selective when taking positions on matters of public interest. Only a select group of individuals are authorized to share Molina's position publicly. Employees and subcontractors should make sure that that any opinion or position they share as an individual or entity does not give the appearance of their speaking or acting on Molina's behalf, unless specifically approved by Molina to do so in advance and in writing.

Interacting with the Media

Molina employees may not speak to the media on Molina's behalf without first coordinating with Molina's designated Communications team. In order to provide accurate and complete information about Molina's business to the media, investment analysts, and the investor community, Molina will respond to the news media in a timely and professional manner only through its designated spokespersons.

Social Media

Social Media means technology tools, websites, and other online applications that provide users the opportunity to create and share content of their choosing, or to participate in social networking. Social Media platforms include blogs, and websites or applications such as Instagram, Facebook, Twitter, Snapchat, LinkedIn, YouTube, etc.
Only designated staff within Molina's public relations or human resources teams are permitted to create or post content on Molina social media platforms.
Molina does not discourage or prohibit employees or subcontractors from using social media in their personal lives, so long as shared content does not conflict with the expectations set forth in this Code. Employees should be aware and cautious of mixing their personal and professional lives when using social media for personal purposes. Employees must remember that all rules regarding member/provider privacy and security, as well as other confidential proprietary information discussed in this Code apply to social media, even within personal profiles. For further guidance, employees are encouraged to refer to **Molina's Social Media Policy** or contact their compliance officer or the human resources department.
Employees and subcontractors shall protect the privacy and security (including cybersecurity) of our members and follow all applicable rules and regulations associated with the HIPAA. Employees and subcontractors must immediately report all good-faith and reasonable suspicions related to a potential violation of this section of the Code.

• Employees must contact the compliance department/chief compliance officer or legal department/chief legal officer, call the Alert Line at (866) 606-3889, or file a report online at **https://molinahealthcare.AlertLine.com**.

• Subcontractors are encouraged to contact their designated Molina contact or relevant compliance officer/chief compliance officer.

Facilities, Environment, Health and Safety

Employees have the right to a safe and clean work environment. Therefore, each employee is responsible for maintaining a workplace that is free of drugs, alcohol, and other harmful materials. This includes explosives, illegal firearms and/or weapons of any sort. Furthermore, actual or threatened violence will not be tolerated. This is very important to our health and safety.

Employees and subcontractors shall not possess, distribute, sell, use, or be under the influence of, or impaired by, alcoholic beverages, illegal or legal drugs while on Molina property, while on duty, or while operating a vehicle or potentially dangerous equipment leased or owned by Molina. Additionally, employees are prohibited from unauthorized removal of Molina property. For further guidance, please review Molina's housekeeping and other facilities policies.

Discrimination, Retaliation and Harassment

Employees have the right to be free of discrimination, retaliation, or harassment of any kind in the workplace. Molina forbids discriminatory harassment with respect to race, color, religion, sex, gender (including gender identity), age, national origin, marital status, sexual orientation, veteran status, disability, genetic information, or any other status or condition protected by federal, state, or local laws.

Any kind of sexual harassment, including quid pro quo sexual harassment, or unwelcome sexual advances (verbal, visual, or physical), requests for favors, and other verbal or physical conduct of a sexual or gender-based nature is prohibited.

Any employee who believes that they are being, or has been, harassed, discriminated or retaliated against should report the issue to their supervisor, manager, department head, or if preferred, their human resources partner immediately.

Employees and subcontractors must immediately report all good-faith and reasonable suspicions related to a potential violation of this section of the Code.

Investigations into an Alleged Violation of this Code

Once a report of an alleged violation of this Code is received, appropriate parties within Molina best experienced to address the allegation will conduct a prompt, fair, and thorough investigation of the alleged violation. All complaints will be kept confidential to the extent possible, but confidentiality cannot be guaranteed based on the context of each situation. All employees and subcontractors must cooperate with all investigations and/or audits conducted as a result of this Code.

Molina will determine whether there has been a violation of this Code based on reasonable evaluation of the credibility of witnesses and information gathered. Upon completion of the investigation, Molina will consider appropriate options for resolution and will take any determined corrective measures against any party who has engaged in conduct that is in violation of this Code if Molina determines such measures are necessary.

Conclusion

This Code helps direct the behavior and decisions of all Molina employees and subcontractors. If anyone – employees, members, providers, contactors, board members or others – has a good-faith belief that a violation of this Code has or will occur, they are required to report it. This vigilance allows us to build on the compliant and ethical conduct that is a Molina hallmark.

Questions

If an employee or subcontractor has any questions pertaining to this Code, the Compliance Plan, policies and procedures, and/or applicable federal and state laws, they are encouraged to contact the following:

- Employees must contact the compliance department/chief compliance officer or legal department/chief legal officer, call the Alert Line at (866) 606-3889, or file a report online at **https://molinahealthcare.AlertLine.com** and must act in accordance with the guidance/advice they receive.
- Subcontractors are encouraged to contact their designated Molina contact or relevant compliance officer/chief compliance officer

MOLINA HEALTHCARE, INC.
CODE OF BUSINESS CONDUCT AND ETHICS
Receipt and Acknowledgement

I acknowledge that I have read, understand, and will adhere to Molina's Code of Business Conduct and Ethics (the "Code") and have familiarized myself with the information therein. I understand that I am governed by the information therein and that Molina may change, rescind, or add to the Code from time to time in its sole and absolute discretion, with or without prior notice. Molina will advise employees of material changes within a reasonable time.

Print Name

Signature

Date

PROPRIETARY AND CONFIDENTIAL