Molina Medicare Compliance Program

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Molina Medicare Compliance Program Introduction

Goals and Components of the Molina Medicare Compliance Program

The Molina Medicare Compliance Program, which includes measures to prevent, detect and correct issues of non-compliance and Fraud, Waste, and Abuse in our Part C and D products (including the Medicare-Medicaid Plan (MMP) product) has the potential of improving the quality, productivity and efficiency of our operations while significantly reducing the probability of improper conduct and legal liability, including but not limited to reducing fraud, waste, and abuse. The Molina Medicare Compliance Program strives to improve operational quality by fulfilling four primary goals:

- Demonstrate our commitment to compliance and ethical and legal business conduct.
- Prevent, identify and correct non-compliant behavior and fraud, waste, and abuse.
- Develop and implement internal controls and processes to promote compliance with State and Federal laws and regulations.
- Establish an environment of open communication that encourages employees and contractors to identify and report potential non-compliant practices, and that disciplines non-compliant behavior.

To achieve these goals, Molina Healthcare has established a Medicare Compliance Program which is comprised of the following key components:

1. **The Molina Healthcare Code of Business Conduct and Ethics** describes the guiding principles of business conduct applicable to all activities conducted by Molina management, staff, and directors. It is a condition of employment with Molina Healthcare to read, understand and abide by the principles outlined in the Code of Business Conduct and Ethics.

2. **The Molina Medicare Compliance and Fraud, Waste, and Abuse (FWA) Plan** describes the elements of an effective compliance program as recommended in the Department of Health and Human Service Office of Inspector General's (OIG) Compliance Program Guidance publications and Federal Sentencing Commission's Guidelines to ensure compliance with applicable federal, state and local statutory and regulatory obligations.

3. **Compliance/FWA Policies and Procedures** describe the processes used by Molina to implement the compliance and fraud, waste, and abuse activities described in the Molina Medicare Compliance and FWA Plan.

Applicability

At Molina Healthcare, Inc., Medicare Operations and Compliance are centralized and are largely performed by Molina Healthcare, Inc. employees. The Molina Medicare Compliance Program applies to Molina Healthcare, Inc. and each of its subsidiaries that administers (or is in the process of applying to CMS for approval to administer) a Medicare Advantage and/or Part D contract, and MMPs, including any employees, officers, and directors that participate in administering the Medicare contracts. Collectively, these entities are referred to as “Company”, “Molina”, or “Molina Healthcare”.

As of 2016, these legal entities consist of the following in alphabetical order:

- Molina Healthcare, Inc.
- Molina Healthcare of California
- Molina Healthcare of California Partner Plan, Inc.
- Molina Healthcare of Florida, Inc.
- Molina Healthcare of Illinois, Inc.
- Molina Healthcare of Michigan, Inc.
- Molina Healthcare of New Mexico, Inc.
- Molina Healthcare of Ohio, Inc.
- Molina Healthcare of South Carolina, LLC
- Molina Healthcare of Texas, Inc.
- Molina Healthcare of Utah, Inc. (also dba Molina Healthcare of Idaho)
- Molina Healthcare of Virginia, Inc.
- Molina Healthcare of Washington, Inc.
- Molina Healthcare of Wisconsin, Inc.

The Molina Healthcare Code of Business Conduct and Ethics

The Board of Directors of Molina Healthcare, Inc. has adopted this Code with respect to the business conduct and practices governing the affairs of Molina Healthcare, Inc. (the "Company"). This Code governs the manner in which the Company's employees, officers, and directors conduct business activities on behalf of the Company.

The Company's continued success will be directly related to our ability to deliver quality services and the ability of our employees, officers, and directors to conduct themselves in accordance with high standards of business ethics and the law.

Every employee, officer, and director must be familiar with it and adhere to it at all times. Any employee, officer, or director in doubt about any aspect of this Code should contact his immediate supervisor, the Compliance Department, or the Company's General Counsel.

The following Code is applicable and binding upon all employees, officers, and directors of the Company.

Unless the context otherwise requires it, wherever a reference to "employee" is made hereafter, this means a reference to a "director, officer, or employee" of the Company.

1. Use of Funds and Assets; Corporate Opportunities; Complete and Accurate Books and Records

    1.1 Provision of the Company's services, and purchases of products and services or supplies, shall be made solely on the basis of quality, price, and service, and never on the basis of giving or receiving payments, gifts, entertainment, or favors.

    1.2 No Company funds or assets shall be used for any unlawful purpose. No employee shall obtain privileges or special benefits through payment of bribes, illegal political contributions, or other illicit payments.

    1.3 Employees owe a duty to the Company to advance the Company's interest when the opportunity to do so arises. Employees are prohibited from:

        a. Taking for themselves personally opportunities that are discovered through the use of Company property, information, or position;

        b. Using Company property, information, or position for personal gain; and

        c. Competing with the Company.

1.4 No undisclosed or unrecorded fund or asset shall be established for any purpose.

1.5 No false or artificial entry shall be made in the books and records of the Company for any reason, and no employee shall engage in any arrangement that results in such prohibited act, even if directed to do so by his or her supervisor.

1.6 All requests for payment shall be supported by a document stating the purpose for the payment. No payment shall be approved or made with the agreement or understanding that any part of such payment shall be used for any purpose other than that described by documents supporting the payment.

1.7 The Chief Accounting Officer shall have the primary responsibility to devise, establish, and maintain an effective system of internal accounting controls and to demonstrate that such controls are documented and periodically appraised.

1.8 The following activities are strictly prohibited by this Code:

a. Offering, promising, or paying money or anything of value to any government employee or official, political party official, or any candidate for political office for any of the following purposes:

- Obtaining or retaining business for the Company;
- Directing business to any person or entity;
- Influencing any act or decision of such official in his or her official capacity;
- Inducing such official to do or refrain from doing any act in violation of his or her lawful duty; or
- Inducing such official to use his or her influence improperly to affect or influence any act or decision.

b. Causing, either directly or indirectly, an offer, promise, or payment as described above to be made through a third party or intermediary.

2. <u>Conflicts of Interest</u>

2.1 Every employee has a duty to avoid business, financial, or other direct or indirect interests or relationships that conflict with the interests of the Company or that divide his or her loyalty to the Company. Any activity that even appears to present such a conflict must be avoided or terminated unless, after seeking advice from the General Counsel, it is determined that the activity is not unlawful, harmful to the Company, or otherwise improper.

2.2 A conflict or the appearance of a conflict of interest may arise in many ways. For example, depending on the circumstances, the following may constitute a conflict of interest:

- Ownership of or an interest in a competitor or in a business with which the Company has or is contemplating a relationship (such as a provider, member, landlord, distributor, licensee/licensor, etc.), either directly or indirectly such as through family members.
- Profiting or assisting others to profit from confidential information or business opportunities that are available because of employment by the Company.
- Providing services to a competitor or a current or proposed contractor or subcontractor as an employee, director, officer, partner, agent, or consultant.
- Influencing or attempting to influence any business transaction between the Company and another entity in which an employee (or a member of employee's family) has a direct or indirect financial interest or acts as a director, officer, employee, partner, agent, or consultant.
- Buying or selling securities of the Company or any other company using non-public information obtained in the performance of an employee's duties, or providing such information so obtained to others.

Loans to employees from financial institutions that do business with the Company are permissible, as long as the loans are made on prevailing "fair market value" terms and conditions.

Accepting gifts, hospitality, and rewards from contractors, suppliers, organizations, and individuals may make it difficult to avoid some obligation to the party offering it, and may later be thought to have affected an employee's impartiality in dealing with that party. Therefore, any such gifts or rewards must be accepted with discretion.

Similarly, it is our policy to exercise discretion in offering gifts or hospitality to customers, suppliers, or any other parties.

The following comments indicate the Company's guidelines on such matters:

a. Receiving Gifts and Hospitality:

In general, it is acceptable to receive small gifts of modest value (e.g., pens, calendars, holiday baskets), particularly if they bear a company's name or insignia and can thus be regarded as being in the nature of advertising matter.

It is not always possible or even desirable to reject modest offers of hospitality and the decision to accept or not depends on the circumstances in each case. Invitations to receptions, luncheons, sports outings, and the like may be accepted if it is felt to be useful to the Company to make contacts, discuss business, or otherwise promote the interests of the business.

b. Giving Gifts and Hospitality:

The guidelines above apply equally to gifts or hospitality given by the Company's employees to others, and modest expenditures should be approved in advance by the General Counsel.

2.3 Any employee who has questions about whether a particular situation in which he or she is involved amounts to a conflict of interest or the appearance of one should disclose the pertinent details, in writing, to his or her supervisor. Each supervisor is responsible for discussing the situation with the employee and arriving at a decision after consultation with the General Counsel, or in his absence the Chief Executive Officer.

3. Protecting the Company's Assets

3.1 The Company has a variety of assets, many of them of substantial value. They include but are not limited to physical things as well as proprietary information that may encompass intellectual property and confidential data. Protecting all these assets against loss, theft, and misuse is vitally important.

3.2 Each employee is responsible for protecting the Company's property entrusted to him or her and for helping to protect the Company's assets in general. Should you observe any situation that could lead to the loss, misuse, or theft of Company assets, you should report the situation to your supervisor as soon as possible.

4. Proprietary Information

4.1 Proprietary information is usually confidential. It includes, among other things, business, financial, marketing plans associated with the Company's services, know-how and processes, business plans, personnel and salary information, patient information, and copyright material associated with our services.

4.2 You must not use or disclose the Company's proprietary information except as authorized by the Company. Similarly, the Company's employees are prohibited from misappropriating the confidential or proprietary information of the Company's competitors.

4.3 Inadvertent disclosure by employees can also harm the Company's interest. You should not discuss confidential information even with authorized persons within the Company 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 fairly complete picture. Further, you should not discuss such information with individuals within the Company who are not authorized to receive such information.

4.4 If questioned by someone from outside the Company about the Company's confidential information, do not attempt to answer unless you are certain you are authorized to do so. If you are not authorized, refer the person to the appropriate company officer.

4.5 If you retire or leave the Company, you may not disclose or misuse the Company's confidential information. Furthermore, the Company's ownership of intellectual property that you created while a Company employee continues after you leave the Company.

5. Compliance with Laws Governing our Business

The Company's business is subject to extensive laws and regulations. Each employee is subject to the Company's Compliance Plan with respect to laws and regulations governing our business.

Each employee is also subject to the Company's Insider Trading Policy with respect to laws and policies respecting transactions in the Company's securities and the securities of other companies.

If an employee has any question whether a transaction or course of conduct complies with applicable statutes or regulations, the Compliance Plan, or the Insider Trading Policy, it is the responsibility of that employee to contact the Compliance Department, or to obtain legal advice from the General Counsel and to act in accordance with that advice.

6. Speaking Out

When speaking out on public issues, each employee should ensure that he or she does so as an individual and does not give the appearance of speaking or acting on the Company's behalf, unless specifically authorized by the Company to do so.

7. Responsibilities of Employees

7.1 All employees are responsible for complying with this Code. Any employee having information concerning any prohibited act, including any fraud, waste, and abuse concerns, shall promptly report such matter to his or her supervisor or the Compliance Officer. The Company will not allow retaliation for reports made in good faith.

7.2 All employees are expected to provide full assistance and disclosure to the Company's internal and external auditors and lawyers in connection with any review of compliance with this Code.

7.3 All employees are expected to endeavor to deal fairly with the Company's regulators, providers, members, competitors, and employees. No employee should take unfair advantage of anyone through manipulation, concealment, abuse of privileged information, misrepresentation of relevant facts, or any other unfair dealing or practice.

7.4 All employees are expected to adhere to privacy rights of patients including all applicable rules and regulations associated with the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA).

8. Responsibilities of Executives

The Company's executive team, including the Chief Executive Officer and the Executive Vice Presidents (each, an "Executive" and, collectively, the "Executives") are required to observe the highest standards of ethical business conduct, including strict adherence to this Code and the letter and spirit of the following:

8.1 Each Executive will act at all times honestly and ethically, including the ethical handling of actual or apparent conflicts of interest between personal and professional relationships. For purposes of Section 8 of this Code, the phrase "actual or apparent conflict of interest" shall be broadly construed and include, 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 even the mere appearance of impropriety.

8.2 Each Executive shall, within his or her areas of responsibility, cause to be taken reasonable and necessary steps to provide full, fair, accurate, timely, and understandable disclosure in reports and documents that the Company files with or submits to the Securities and Exchange Commission, and in all other regulatory filings. In addition, each Executive must provide full, fair, accurate, and understandable information whenever communicating with the Company's stockholders or the general public.

8.3 It is each Executive's responsibility to notify promptly the General Counsel or Chairman of the Board regarding any actual or potential violation of this Code by any Executive or any employee. It is the duty of the General Counsel or the Chairman of the Board of Director to cause to be conducted a thorough investigation of the alleged violation by an appropriate disinterested party. All Executives are responsible for ensuring that his or her own conduct complies with this Code.

9. <u>Waivers</u>

The Board of Directors of the Company shall be responsible for the administration of this Code and shall have the sole authority to grant waivers of its provisions. Any explicit or implicit waiver of a provision of this Code with respect to an Executive or a member of the Board of Directors shall be promptly disclosed to the public in a Current Report on Form 8-K filed with the Securities and Exchange Commission.

10. <u>Reporting Violations</u>

Employees, Executives, and members of the Board of Directors must report violations of law and/or the Company's policies, including non-compliance with respect to fraud, waste, and abuse laws and/or policies, to the Compliance Department or to the General Counsel.

The Molina Medicare Compliance and Fraud, Waste, and Abuse (FWA) Plan

The Molina Medicare Compliance and FWA Plan document describes the seven key required elements for achieving and maintaining compliance with the Federal and State laws and regulations listed below, as well as measures to prevent, detect, and correct fraud, waste, and abuse and non-compliance in the delivery of Medicare Part C and D services, as well as by Molina Healthcare and its contracted entities and individuals.

The Federal and state compliance obligations that Molina must comply with include, but are not limited to, the following statutes, regulations, and guidelines:

1. Applicable State laws and contractual commitments
2. Federal False Claims Act: prohibits knowingly presenting (or causing to be presented) to the federal government a false or fraudulent claim for payment or approval
3. Anti-Kickback Statute: provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce or reward business payable (or reimbursable) under the Medicare or other Federal health care programs
4. Health Insurance Portability and Accountability Act (HIPAA)
5. Code of Federal Regulations, specifically 42 C.F.R. § 400, 403, 411, 417, 422, 423, 1001 and 1003.
6. Regulatory guidance produced by the Centers for Medicare and Medicaid Services (CMS), including requirements in the Medicare Managed Care Manual (MMCM) and the Prescription Drug Benefit Manual (PDBM), as well as all other policy guidance
7. Applicable provisions of the Federal Food, Drug and Cosmetic Act

The Molina Medicare Compliance Program is fully committed to these obligations, and specifies the manner in which employees and contractors will comply with them through this Compliance and FWA Plan and related policies and procedures.

Elements of the Molina Medicare Compliance and FWA Plan

The Molina Medicare Compliance and FWA Plan includes the seven compliance elements of an effective compliance program as required by the Medicare Part C and D statutes (42 CFR 422.503(b)(4)(vi) and 42 CFR 423.503(b)(4)(vi)):

1. Molina maintains written policies and procedures and a Code of Business Conduct and Ethics that articulate Molina’s commitment to comply with all applicable Federal and State laws.

2. Molina designates a Medicare Compliance Officer and Medicare Compliance Committee and high level oversight that is accountable to the Board of Directors.
3. Molina provides effective training and education between the Medicare Compliance Officer, Compliance Committee, employees, directors, subcontractors and vendors as required by Medicare.
4. Molina maintains effective lines of communication between the Medicare Compliance Officer, employees, directors, subcontractors, and vendors as required by Medicare.
5. Molina enforces standards through well-publicized disciplinary guidelines, including policies and procedures for dealing with sanctioned individuals and entities.
6. Molina maintains a system for routine monitoring and auditing and identifies compliance risks of its operations in accordance with the CMS contract.
7. Molina maintains procedures for ensuring prompt response to detected offenses and development of corrective action initiatives for both issues of non-compliance and fraud, waste, and abuse.

Element 1: Written Policies, Procedures and Standards of Conduct

The Code of Business Conduct and Ethics and written policies and procedures are two of the three key components of the Molina Medicare Compliance Program (the third is the Molina Medicare Compliance and FWA Plan). The Code of Business Conduct and Ethics, approved by the Molina Healthcare Board of Directors, articulates the standards by which employees, management, and directors of Molina Healthcare must conduct themselves in order to protect and promote organization-wide integrity and to enhance Molina's ability to achieve its mission. The Code of Business Conduct and Ethics is distributed in hardcopy to the following:

1. All employees, including management, within 90 days of hire, and annually thereafter.

2. All Molina Healthcare Directors at the time of appointment to the Board, annually thereafter.

3. All contractors/vendors, including first-tier, downstream, and related entities at the time of contract signature, and annually thereafter.

Additionally, the Code of Business Conduct and Ethics is made available to Molina employees and directors via the Molina Medicare intranet site.

Molina Medicare has developed an extensive set of policies and procedures to implement the Molina Medicare Compliance and FWA Plan, ensure compliance, and articulate Molina's commitment to comply with all applicable Federal and State standards. These policies and procedures describe Molina's compliance expectations as indicated in the code of business conduct, as well as the implementation and operation of the Molina Medicare Compliance

Program. Additionally, these policies and procedures provide guidance on dealing with potential employees issues, identifies how to communicate compliance issues to the Molina Medicare Compliance Department, and describes how potential compliance issues will be investigated and resolved by the applicant.

As with the Code of Business Conduct and Ethics, the policies and procedures are made available to Molina employees and directors via the Molina Medicare intranet site.

Whenever there is a change in federal or state law, regulations, or policy guidance, the Medicare Compliance Department reviews the Code of Business Conduct and Ethics, the Medicare Compliance and FWA Plan, and compliance policies and procedures to determine if revisions are necessary, or if new policies and procedures must be created. If so, the Medicare Compliance Department promptly revises the Code of Business Conduct and Ethics, Medicare Compliance and FWA Plan, and/or policies and procedures (or creates new policies and procedures, if applicable). Medicare Operations conducts a similar review of applicable operational policies and procedures, and make revisions as necessary. Approved versions of new and/or revised policies and procedures are made available to Molina employees and directors via the Molina Medicare intranet site.

In order to promote an environment of open communication and reporting, Molina has and enforces a policy of non-retaliation and non-intimidation for good faith participation in the Molina Medicare Compliance Program, including, but not limited to reporting potential compliance issues, investigating compliance issues, conducting self-evaluations, audits and remediation actions, and reporting to the appropriate Molina officials.

Element 2: Compliance Officer, Compliance Committee, and High Level Oversight

Molina Medicare has a dedicated Compliance Officer who has primary responsibility for the day-to-day operation and oversight of the Molina Medicare Compliance and FWA Plan. The Medicare Compliance Officer is responsible for the implementation of the compliance plan, defining the plan structure, educational requirements, reporting, and complaint mechanisms, response and corrective action procedures, and compliance expectations of all employees and first tier, downstream, and related entities. This position will continue to be filled by a Molina Healthcare employee. At no time will this position be filled with an employee of a first tier, downstream, or related entity. The Compliance Officer has the express authority to provide unfiltered, in-person reports to Senior Leadership and the Board of Directors.

Reporting Structure

The Medicare Compliance Officer reports directly to the Compliance Committee of the Molina Healthcare Board of Directors (the Subcommittee). The Medicare Compliance Officer meets with the Subcommittee at least quarterly to report on compliance issues and obtain guidance and feedback from the Subcommittee. Molina Healthcare, Inc. Board of Directors is knowledgeable about the content and operation of the Molina Medicare Compliance Program and continues to exercise reasonable oversight regarding the implementation and effectiveness of the program.

The Medicare Compliance Officer meets with the Vice-President and Senior Vice President responsible for Medicare bi-weekly to discuss compliance and fraud, waste, and abuse activities. Although the Medicare Compliance Officer does not report to senior management, it is critical to keep senior management apprised of investigations, audits, monitoring activities, training, and other compliance and FWA-related issues on an ongoing basis. The Vice-President and Senior Vice President responsible for Medicare provide guidance, feedback, and direction to the Medicare Compliance Officer.

The Medicare Compliance Officer serves a consultative role to the Vice President and Senior Vice-President of Medicare. Although there is no direct line of authority to the Vice President or Senior Vice-President of Medicare, the Medicare Compliance Officer plays an important role in informing the Vice President and Senior Vice-President of compliance and FWA issues that impact the ongoing operation of Molina Medicare products.

Responsibilities—Molina Medicare Compliance Department (MMCD)

The Medicare Compliance Officer oversees the Medicare Compliance Department and the following directors (who report directly to the Medicare Compliance Officer):

Director of Compliance – Audits,
Director of Compliance – Regulatory Analysis,
Director of Compliance – Delegation Oversight
Director of Compliance – Reporting, Training, and FWA; and
Director of Compliance – Medicare Medicaid Plans.

The responsibilities of the Medicare Compliance Department include:

1. Overseeing and monitoring the implementation of the Molina Medicare Compliance Program.
2. Amending the Molina Medicare Compliance Program as needed to reflect changes in the law, healthcare marketplace and the development of the company.
3. Distributing the Code of Business Conduct and Ethics, the Medicare Compliance and FWA Plan, and written compliance/FWA policies and procedures that promote and pertain to Medicare compliance.
4. Developing, coordinating and conducting training and education that focuses on the elements of the Molina Medicare Compliance Program and seeking to ensure that all appropriate employees and management are knowledgeable of and comply with Federal and State law.
5. Ensuring that the Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) and the Systems for Award Management (SAM) list of debarred contractors for both Molina employees and first-tier, downstream, and related entities is checked at the time of hire/contract as well as monthly and ensuring documentation is maintained on the process for all employees and first-tier, downstream, and related entities.
6. Reviewing findings and recommendations of OIG and CMS fraud alerts, reports and studies; and updating the Medicare Compliance and FWA Plan and Code of Business Conduct and Ethics accordingly.
7. Conducting annual risk assessments, from which oversight, monitoring and audit activities will be scheduled for the coming year.
8. Overseeing monitoring activities, including analyzing performance data and metrics received from all Medicare operational departments.
9. Overseeing monitoring activities related to compliance and fraud, waste, and abuse that are performed by Molina staff and first-tier, downstream, and related entities.
10. Ensuring that first tier entities, downstream entities, and related entities, particularly those involved in sales and marketing activities, follow the requirements for Medicare sales and marketing activities.
11. Conducting internal audits of Medicare operational areas identified at risk of non-compliance through the annual risk assessment process, as well as ad hoc internal audits for areas in which issues are identified outside the annual risk assessment process.
12. Conducting audits of Medicare activities conducted by first-tier, downstream, and related entities that are identified at risk of non-compliance.
13. Monitoring of policies and programs that encourage managers, employees, first tier entities, downstream entities and related entities to report suspected non-compliance or fraud, waste, and abuse anonymously and without fear of retaliation.

14. Receiving and investigating matters related to compliance submitted by Molina employees, management, directors, and/or individuals from first-tier, downstream, and related entities.
15. Responding to potential instances of Medicare fraud, waste, and abuse, including the coordination of investigations and the development of appropriate corrective or disciplinary actions when necessary.
16. Coordinating potential fraud investigations and referrals with the appropriate MEDIC and facilitating any document or procedural request that the MEDIC makes. The Molina Medicare Compliance Officer, as appropriate, will collaborate with other Sponsors, state Medicaid programs, Medicaid Fraud Control Units (MFCUs) and other organizations when a fraud, waste, and abuse issue is discovered involving multiple parties.
17. Developing, implementing and evaluating corrective actions resulting from confirmed non-compliance and/or fraud, waste, and abuse.
18. Enforcing appropriate and consistent disciplinary action, including termination, in conjunction with the Human Resources Department, against employees who have engaged in acts or omissions constituting non-compliance or acts of fraud, waste, and/or abuse.
19. Enforcing appropriate and consistent disciplinary action, including contract termination, against first-tier, downstream, and related entities who have engaged in acts or omissions constituting non-compliance.
20. Maintaining a document control system for all reports and operations of the Medicare Compliance Department and the Medicare Compliance Committee, including minutes of meetings, audit and monitoring reports, disciplinary action, investigations, disclosures, government inspections and training activities.

Responsibilities—Molina Medicare Compliance Committee

The membership of the Molina Medicare Compliance Committee is selected by the Molina Medicare Compliance Officer who considers the input of Medicare senior management in the selection process. The members of the Molina Medicare Compliance Committee perform their duties under the guidance of the Molina Medicare Compliance Officer. The membership of the Molina Medicare Compliance Committee consists of senior level management representatives from the following departments:

1. Sales and Marketing
2. Claims
3. Pharmacy
4. Membership Services/Appeals and Grievance

5. Medical Management
6. Enrollment
7. Provider Relations
8. Medicaid Compliance
9. Medicare Compliance
10. Special Investigation Unit (SIU)

The Molina Medicare Compliance Officer serves as the Chair of the Molina Medicare Compliance Committee and has final decision-making authority over recommendations made by the Molina Medicare Compliance Committee.

The Molina Medicare Compliance Committee advises and supports the Molina Medicare Compliance Officer with respect to implementing the Molina Medicare Compliance Program. The Molina Medicare Compliance Committee reports to and takes direction from the Molina Medicare Compliance Officer.

The Molina Medicare Compliance Committee meets quarterly, or more frequently as necessary. The Molina Medicare Compliance Committee’s responsibilities include, but are not limited to, assisting the Molina Medicare Compliance Officer in:

1. Developing strategies to promote compliance and the detection of any potential violations.
2. Ensuring that training and education are appropriately completed for employees and first-tier, downstream, and related entities, to maintain compliance.
3. Making recommendations for and approval of the annual Medicare Compliance Risk Assessment and Audit Work Plan.
4. Working with appropriate departments as well as affiliated providers to develop and distribute the Code of Business Conduct and Ethics and policies and procedures that promote adherence to the Molina Medicare Compliance Program.
5. Overseeing a system of internal controls to carry out the Molina Medicare Compliance Program and Code of Business Conduct and Ethics as part of its daily operations.
6. Identifying areas of compliance deficiency to monitor ongoing compliance, and to assess the effectiveness of compliance corrective measures with use of audits, investigations and other evaluation techniques.
7. Ensuring Molina has a system for employees, first-tier entities, downstream entities and related entities to ask compliance questions and report potential instances of fraud, waste, and abuse (confidentially or anonymously) without fear of retaliation.

8. Reviewing and addressing reports of monitoring and auditing of areas in which Molina is at risk of fraud, waste, and abuse.
9. Monitoring internal and external audits and investigations for the purpose of identifying troublesome issues and deficient areas experienced by Molina.
10. Overseeing corrective action plans and ensuring that they are implemented and monitored and are effective in correcting the deficiency.
11. Providing regular ad hoc reports on the status of compliance with recommendations to the Board of Directors.

Element 3: Effective Training and Education

The Molina Medicare Compliance and Fraud, Waste, and Abuse Plan is only effective if Molina employees, including the Chief Executive Officer, Senior Management, managers, Board of Directors, and first-tier, downstream, and related entities understand the requirements with which they must comply and are kept up-to-date with changing Medicare laws, regulations and policy guidance. Completing the Molina Medicare compliance and fraud, waste and abuse training programs is a condition of continued employment with the Company. Failure to comply with training requirements may result in disciplinary action.

The Medicare Compliance Department is responsible for the development and maintenance of a training and education program for compliance and fraud, waste and abuse. This training and education program is conducted for new employees, including the chief executive and senior administrators within 90 days of hire and annually thereafter through online training modules. These training programs are updated prior to annual training to incorporate any changes to Federal or state laws or regulations regarding compliance and/or fraud, waste and abuse requirements. In the event of significant changes to Federal or state laws or regulations that require retraining sooner than the annual training, the Medicare Compliance Department will update the training programs and conduct training sessions via the online training modules as expeditiously as possible. Because it is imperative that Molina Board members are aware of and comply with all compliance and FWA requirements, general compliance and FWA training is also mandatory for all Board members. This training is conducted within 90 days of appointment to the Board and annually thereafter. The Compliance Department is responsible for maintaining documentation of attendance and training content for training provided to Board members. Molina will maintain training records for a period of 10 years of the time of attendance topic, and test scores of any tests administered to its employees and Board of Directors. Additionally, Molina requires first-tier, and downstream related entities to maintain records of the training of their employees.

The training and education component of the Molina Medicare Compliance and Fraud, Waste and Abuse Plan includes two different types of training:

General Compliance Training - The general compliance training includes, but is not limited to, the following topics:

- A review of the Molina Medicare Code of Business Conduct and Ethics, Molina Medicare Compliance and FWA Plan, and compliance policies and procedures;
- Review of applicable Federal and state laws and regulations, such as the False Claims Act, the Anti-Kickback Statute, and Medicare regulations related to compliance program requirements.
- Discussion of the various methods on how to ask compliance questions, and to identify and report suspected non-compliance and/or fraud, waste and abuse to the appropriate Molina staff, including Molina's policy on confidentiality, anonymity and non-retaliation.
- Discussion of responsibility to report suspected instances of non-compliance with Federal and state laws, including how, where and to whom such instances should be reported.
- Discussion of Molina's disciplinary guidelines when non-compliant behavior is confirmed, including disciplinary action and possible termination when such behavior is serious or repeated, as well as a discussion of how adherence to the Medicare Compliance Program is considered in employee evaluations.

Fraud, Waste, and Abuse (FWA) Training - The FWA training includes, but is not limited to, the following topics:

- Definitions of fraud, waste, and abuse.
- Descriptions of potential FWA activities conducted by pharmacies, healthcare providers and members.
- Methods used by Molina to prevent, detect, and correct instances of fraud, waste and abuse.
- Discussion of responsibility to report suspected instances of fraud, waste and abuse, including how, where and to whom such instances should be reported.
- Discussion of availability of anonymous reporting and Molina's policy of non-retaliation of employees and/or contractors who report suspected fraud, waste and abuse.
- Conflict of Interest policy.
- Review of policies and procedures as available internal resources covering all aspects of the program, including standards of conduct, compliance, and methods for reporting fraud, waste, and abuse.
- Discussion of relevant Federal laws related to the prevention, detection and correction of fraud, waste and abuse, such as the Federal False Claims Act, the Anti-Kickback Statue, HIPAA requirements, etc.

- Roles of Molina, the MEDIC, CMS, and law enforcement agencies in combating fraud, waste and abuse.
- Specialized or refresher trainings may be provided on issues posing fraud, waste, and abuse risks based on the individual's job function.

Compliance and FWA training for first-tier, downstream, and related entities (FDR): Molina requires both compliance and FWA training within 90 days of contract signature and annually thereafter for FDRs. For those FDRs that have developed their own compliance and FWA training and wish to utilize that training in lieu of Molina's compliance and FWA training, the FDR may submit their internal training programs to the Molina Medicare Compliance Department for review and approval as a suitable alternative to Molina's training programs. If the FDR does not have its own internal compliance and FWA training or their internal training program is not approved by the Molina Medicare Compliance Department, Molina will provide compliance and FWA training materials to the FDR. Whether the FDR uses its own internal training or the Molina training, the FDR must submit to the Molina Medicare Compliance Department a signed, dated attestation within 90 days of contract signature stating that all employees of the first-tier entity have completed both the compliance and FWA training. The attestations are maintained by the Medicare Compliance Department.

For annual compliance and FWA training, the Medicare Compliance Department contacts all FDRs annually to determine whether the FDR will be utilizing its own compliance and FWA training programs or Molina's training programs. If the FDR wishes to use its own internal training program, it must be submitted to the Medicare Compliance Department within 15 calendar days of contact from the Medicare Compliance Department for review and approval, so that the Medicare Compliance Department can ensure the training reflects the most current Federal and state laws, regulations, and policies on compliance and fraud, waste and abuse. If the FDR does not have its own internal, updated compliance and FWA training, or the Medicare Compliance Department does not approve the FDRs training program, the FDR is required to use Molina's compliance and FWA training program. The FDR must submit a signed, dated attestation indicating that all employees of the FDR have completed both the compliance and FWA training. The attestations are maintained by the Medicare Compliance Department.

First-tier, downstream, and related entities who have met the fraud, waste, and abuse certification requirements through enrollment into the Medicare program or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) are deemed to have met the training and educational requirements for fraud, waste, and abuse.

Element 4: Effective Lines of Communication

In order for Molina to be able to respond quickly, effectively and thoroughly to any potential compliance and/or fraud, waste and abuse issues, it is critical to have and implement effective lines of communication, ensuring confidentiality between the Compliance Officer and his/her designee and employees, members, and first tier, downstream, and related entities, agents, directors, the Medicare Compliance Committee, Molina leadership, and the Board of Directors.

The Medicare Compliance Department encourages all parties (employees, Medicare members, FDRs, agents, directors and Molina leadership) to report suspected instances of non-compliance and/or fraud, waste and abuse related to the Medicare program either to the Medicare hotline or to the Medicare Compliance Officer. Reporting of suspected instances of non-compliance and/or fraud, waste and abuse can be reported anonymously through the Compliance hotline or the Medicare Compliance Officer. In the case of Molina employees, it is Molina's policy that any suspected instances of non-compliance or FWA <u>must</u> be reported to the Medicare Compliance Officer, either directly or indirectly through the Medicare hotline. Any employee found to have known of such allegation but failed to report it may be subject to disciplinary action. In order to promote an environment of open communication and reporting, Molina has and enforces a policy of non-retaliation and non-retribution toward any party reporting suspected instances of non-compliance or FWA.

CONFIDENTIAL Compliance and FWA Hotline

Molina Healthcare maintains a confidential compliance hotline. Molina employees who work with the Medicare product are informed of the confidential compliance hotline via initial and annual compliance and FWA training, Molina compliance hotline posters are placed in common areas in Molina offices nationwide. Members are informed of the confidential compliance hotline via the Molina Medicare website. Providers are informed of the confidential compliance hotline through the Provider Manual and the Molina Medicare website. FDRs are informed of the confidential compliance hotline through outreach and FWA training.

Reporting to the Medicare Compliance Officer

In addition to the compliance hotline, parties may also choose to confidentially or anonymously report suspected instances of non-compliance or fraud, waste and abuse directly to the Medicare Compliance Officer. Reports may be made by secure voicemail, email, or mail.

Molina educates employees about the reporting and investigation process through initial and annual compliance and FWA training, the Molina Medicare Compliance and FWA Plan, and related policies and procedures.

Molina educates its members about identification and reporting of non-compliance or potential fraud, waste, and abuse via the Molina Medicare website.

Element 5: Well-Publicized Disciplinary Standards

For the Molina Medicare Compliance and FWA Plan to be effective, it must include strong disciplinary guidelines to enforce the Code of Business Conduct and Ethics and other aspects of the Compliance Program. Enforcement is conducted through timely sanctions for non-compliant or unethical behavior, dealing consistently and appropriately with violations, implementing and following up appropriately with corrective action plans, utilizing a tracking system for disciplinary actions, and providing incentives to reward compliance efforts. Molina employees, including executive, management, and support staff, are expected to conduct Medicare activities in conformance with Federal and state requirements and internal policies and procedures. Staff who fail to meet this standard, including managers and department directors who condone or fail to prevent improper conduct, are subject to disciplinary action, up to and including termination of employment. The Medicare Compliance Officer is responsible for ensuring that disciplinary actions are enforced on a fair and consistent basis by participating in the development and effectuation of those actions in conjunction with Human Resources and the applicable department director. Additionally, Molina Medicare employees are evaluated on adherence to the Code of Business Conduct and Ethics and other aspects of the Compliance Program as part of their annual performance review.

Publicizing Disciplinary Guidelines

To deter incidents of unethical or noncompliant behavior by Molina employees, Molina publicizes disciplinary guidelines in the initial and annual compliance and FWA training; by distributing compliance/FWA policies and procedures to employees at the time of hire and annually thereafter. Additionally, the compliance/FWA policies and procedures are posted to Molina's company intranet site. To deter incidents of unethical or noncompliant behavior by employees of FDRs, Molina shall establish an enforcement system.

Enforcement

Employees*:* Following an investigation that confirms a Molina employee has violated one or more of the elements of the Code of Business Conduct and Ethics and/or a provision of the Molina Medicare Compliance and FWA Plan, disciplinary action will be taken. All acts of discipline will include consultation with Human Resources prior to final action.

Element 6: Effective System for Routine Monitoring, Auditing, and Identification of Compliance Risks

Under the direction of the Medicare Compliance Officer, the Medicare Compliance Department establishes and implements an effective system for routine monitoring and identification of compliance risks. The Medicare Compliance Department performs an annual risk assessment to develop an overall internal monitoring and auditing work plan for the year to address risks posed both by non-compliance with CMS Part C and D requirements.

Risk Assessment

The risks associated with each Medicare Part C and D requirement are determined by reviewing the operational processes, documentation, interviews, and system walkthroughs for all functional areas together to provide a 360-degree analysis to determine the potential risks to current and prospective members, providers, pharmacies, PBMs, wholesalers, manufacturers, and Molina itself. The plan utilizes the following inputs to establish the annual risk assessment:

Molina Identified Risks:

- Monitoring and Auditing results
- Potential and Confirmed Compliance Incidents (PCI/CCI)
- Key Performance Indicators
- Risk Identification Survey

CMS Identified Risks:

- Audit Program Process and Protocols
- One Third Financial Audits
- Compliance Notices (Notice of Non-Compliance, Warning Letters, Corrective Action Plans)
- Monitoring Projects

- Agency communications of planned areas of focus through HPMS memos, conference presentations and conference calls.
- Plan Sanctions (CMS issued plan sanctions on other health plans and their respective civil monetary penalties)
- Complaint Tracking Module (CTM)
- Office of Inspector General OIG annual work plan

The two key steps in the risk assessment process are discovery and analysis. Discovery is the process of determining which requirements are completely implemented, their operational effectiveness, and how the practices and the documentation support compliance. In most cases, the discovery process includes document review, interviews with relevant Medicare staff, and system walkthroughs. It also includes a risk identification survey for inputs directly from department management. The survey results are evaluated, assessed and used as part of the broader compliance risk assessment and prioritization initiative.

The identification of risk is not a static process, as risks can be impacted due to new or revised regulations and guidance. Because of rapidly changing CMS policy, risks can change, sometimes significantly, as frequently as month to month. It is possible to have a situation where the audit schedule is based on an effective risk assessment process, but by the time the scheduled internal audits are to be performed, the risk profile has evolved and the planned audits are no longer sufficient. To combat the issue of risk evolution, the Medicare Compliance Department:

- Recognizes the dynamic nature of risk, and performs internal monitoring activities in order to continually assess risks in real time and make adjustments to the internal audit schedule accordingly;
- Begins each scheduled internal audit by refreshing the risk assessment component of that particular audit to ensure the audit covers the appropriate scope of operations;
- Is flexible with respect to the audit timeframes and adapts audit procedures as new guidance is released or as CMS policy changes.

The Annual Risk Assessment and Work Plan is submitted to the Molina Medicare Compliance Committee for approval and is presented to the Compliance Committee of the Molina Board of Directors. Any revisions to the Risk Assessment and Work Plan will be handled in the same manner.

Internal Audit Work Plan

Once completed, the results of the risk assessment are used to establish the audit work plan. The activities included in the annual audit work plan are designed to test and confirm compliance with the Medicare Advantage and Medicare Part D regulations, sub-regulatory guidance, and applicable Federal laws. The Medicare Compliance Program is routinely evaluated by the Medicare Compliance Officer to ensure it is effective in identifying, correcting and reporting issues of non-compliance and risks that have the potential of leading to non-compliance. Auditing of Compliance Program effectiveness is included in the audit work plan, and results are reported to the Compliance Committee, Senior Management, and the MHI Board of Directors. This process of continuous improvement assists with program optimization and results in greater program effectiveness.

The internal audit schedule includes:

- the operational area and department function that will be audited;
- the type of auditing activity that will take place (i.e. audit, validation audit, assessment or review);
- the department that conducts the activities that will be audited;
- when the audit will occur (i.e. in which quarter the audit will take place);
- who is responsible for conducting the audit.

The audit frequency is determined based on the identified risk for that area and whether the area is determined to be high, medium, or low risk. Generally, risk areas and audit timeframes are defined as follows:

- High-risk areas are audited quarterly to annually;
- Medium-risk areas are audited bi-annually;
- Low-risk areas are audited every 1-3 years.

Internal Monitoring

Monitoring and oversight is conducted directly by the Compliance Department as well as through self-monitoring for compliance by the operational areas. Management of monitoring and oversight information is primarily accomplished utilizing the Gorman Online Management Tool (OMT) which is a secure, web-based compliance tool. OMT is an oversight and performance management program to track:

- Ongoing Monitoring
- Focused Auditing

- Corrective Actions
- Implementation of New Requirements

Integration between modules allows for the connection of metrics, documentation and requirements, as well as corrective actions, regulatory notices, and audits. Core functionality is enhanced by the addition of maintained content, including documents, elements, and audit tools such as integrated CMS-style worksheets.

The Medicare Compliance Department (MCD) monitors Key Performance Indicators (KPIs) on a monthly basis. This is comprised of results of key compliance metrics reported by 17 functional areas from all Molina Medicare plans. If an indicator fails to meet the established benchmark for a given month, the functional area is required to submit a Corrective Action Plan (CAP) which includes a root cause assessment, resolution, actions to prevent future reoccurrence, and an expected date of compliance. KPI outliers are reported to Senior Leadership via the monthly Key Performance Outlier Report. The KPI Outlier Report is also reviewed by the Medicare Compliance Committee, and reported to the Compliance Committee of the Molina Board of Directors.

OMT Components

The OMT contains the following modules that are utilized by the MCD and functional departments:

- Key Performance Indicators (KPIs) – Individual pieces of data or plan tasks, reported regularly by functional area. This is a self-reporting module, where users within each functional area input plan data and determine compliance for audit guide elements.
- Audit Guide Elements – Elements from the CMS MA and Part D Audit Guides, determined regularly by functional area utilizing KPIs and other documentation
- Internal Audit Module – Ad hoc reporting of Audit Guide or Plan defined elements
- Corrective Action Plans – Assigned to KPIs or elements and tracked until closed
- Document Library– Repository of all plan documentation
- Messaging System – Message system, documenting and archiving compliance decisions

Exclusion Screening and Monitoring

Molina performs prospective and retrospective screenings of personnel and FDRs against the OIG's List of Excluded Individuals/Entities (LEIE) and GSA's System for Award Management (SAM) exclusion lists. Prior to any offer of employment, appointment, or contract, Molina checks the

LEIE and SAM for all candidates, board members, officers, contractors, and FDRs. Each month, the LEIE and SAM are checked for all employees, board members, officers, contractors, and FDRs to ensure that no existing individuals or entities are on the list.

The Molina Credentialing Department employs a rigorous process to ensure providers are suitable for serving plan membership. Molina uses credentialing software system to electronically track the credentialing process and each Molina state health plan maintains a credentialing committee to govern the process. Each provider is initially screened against the LEIE and SAM and then on a monthly basis the entire provider network is reviewed against the exclusion lists to ensure no practitioners are excluded from participation. If a provider is identified as being excluded from federal participation, they are immediately flagged in the claims payment system so no claim payments can be made to the provider.

Internal Monitoring and Auditing of Possible Fraud, Waste and Abuse

Molina and its FDRs engage in a variety of monitoring and auditing activities focused proactively on identifying fraud, waste and abuse among physicians, pharmacies, and members. Molina and its FDRs revise and refine their monitoring and auditing activities aimed at fraud, waste and abuse as new schemes and methods are uncovered in the industry.

Monitoring and Auditing of First Tier, Downstream, and Related Entities (FDRs)

Molina contracts with various parties to administer and/or deliver some MA and Part D benefits on Molina's behalf. To ensure that its first tier entities are in compliance with all applicable laws and regulations, and to ensure that the first tier entities are monitoring the compliance of the entities with which they contract (Molina's "downstream entities"), Molina conducts routine audits and monitoring of its highest risk first tier entities.

Delegation Oversight staff conduct the on-site and/or desk audits, identify deficiencies and request corrective action plans as needed. The Delegation Oversight staff then schedule a validation audit to verify that all issues have been rectified. In addition to auditing for adherence to Part C and Part D requirements for the delegated functions, the first tier entities are evaluated for applying appropriate compliance program requirements to downstream entities with which they contract. The audit reports and corrective action plans are submitted to a Delegation Oversight Committee for review and approval. The Medicare Compliance Officer and the Compliance Director of Delegation Oversight are members of the Delegation Oversight Committee.

Monitoring activities include but are not limited to review of daily, weekly, monthly and quarterly reports submitted by the FDRs and Key Performance Indicators (KPIs) developed to

measure adherence to CMS Part C and D requirements. FWA Monitoring activities rely primarily on data analysis to identify non-compliance, patterns of aberrant and potentially abusive utilization, and other forms of fraud, waste and abuse, and are conducted by Molina and by FDRs. The FDRs are also audited either by Molina, or by FDRs (for example, the contracted Pharmacy Benefit Manager (PBM) conducts audits of contracted pharmacies) to ensure that they are in compliance with all applicable laws and regulations, and to ensure that the FDRs are monitoring the compliance of the entities with which they contract.

The Compliance Director of Auditing and the Compliance Director of Delegation Oversight consult with each other as the Director of Delegation Oversight develops the FDR annual risk assessment. The FDR annual risk assessment process determines the monitoring and auditing work plan for the year.

The FDR monitoring schedule includes:

- the requirements that will be monitored;
- how each requirement is monitored (e.g., reports, metrics, etc.);
- the due date of the monitoring activity;
- which department is responsible for submitting the monitoring data to the Medicare Compliance Department;
- the period of time covered by the reports or other data; the estimated time required for the applicable department to generate the data, as well as the review time by the Medicare Compliance Department.

The FDR audit schedule includes:

- the requirements that will be audited;
- the department that conducts the activities that will be audited;
- when the audit will occur (i.e., Q1, Q2);
- the period of time covered by the audit;
- who is responsible for conducting the audit.

Some of these monitoring and audit activities include:

- Analysis of prescription data in order to identify outlier prescription claims that may be the result of fraudulent or abusive behaviors, such as controlled substances prescribing patterns;
- Examination by Molina’s contracted Pharmacy Benefit Manager (PBM) of utilization activity for specific clinical patterns including, but not limited to:

  - Pharmacy High Dollar Claims Utilization
  - Pharmacy Atypical-Antipsychotic Utilization Report
  - Pharmacy Inhalation Medication Review
- PBM desk and onsite audits of pharmacies to identify claims discrepancies and overpayments; and
- Part D claims review by a contracted vendor to detect coding and billing errors.
- PBM attendance at quarterly National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC) meetings to coordinate efforts with other Medicare Part D plan sponsors, the NBI MEDIC, and HHS-OIG. All pharmacies identified in these meetings are added to the PBM investigative audit program for further evaluation.

When corrective action is needed by the FDR, the Compliance Director of Delegation Oversight or his/her designee will ensure that corrective actions are taken by the entity.

Molina's Special Investigation Unit (SIU)

Molina's SIU supports the Medicare Compliance Officer in preventing, detecting, investigating, and reporting all suspected, potential or confirmed fraud, waste, and abuse to the NBI MEDIC.

The SIU Associate Vice-President is responsible for coordinating with the Molina Medicare Compliance Department to conduct objective fraud, waste, and abuse investigations. The purpose of an investigation is to gather evidence related to an allegation to determine the likelihood that potential fraud, waste, or abuse occurred. Cases referred to the SIU will be investigated timely, with not more than two weeks lapsing after the date the potential fraud, waste, and abuse was identified to begin the preliminary investigation process.

In an effort to reduce and deter fraud, waste, and abuse case, 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 this review.

If after the investigation of a potential fraud, waste, and abuse it is determined that there is potential or confirmed fraud, waste, and abuse, the SIU Associate Vice-President, or her/his designee will provide a written report to the NBI MEDIC by submitting the designated referral form, which contains all the data elements required by the NBI MEDIC, and will report the findings back to the Medicare Compliance Department.

The SIU maintains strict confidentiality of all reports, records, and investigations of suspected fraud, waste, and abuse. The SIU retains records obtained as the result of an investigation for a minimum period of 10 years.

Element 7: Procedures and System for Prompt Response to Compliance Issues

Investigation of Reported Non-Compliance or Suspected Fraud and Improper Conduct

All reports of suspected improper conduct, non-compliance, and/or fraud, waste or abuse are investigated promptly and thoroughly by the Medicare Compliance Department, under the direction of the Medicare Compliance Officer and/or his designee. Every effort is made to maintain the confidentiality of reports of potential violations and concerns about fraudulent, illegal or non-compliant behavior, however, there may be a point where the identity of the person filing the report may become known or may have to be revealed in the course of the investigation or to take corrective action.

All allegations of non-compliance and fraud, waste, or abuse are routed to the Medicare Compliance Department, regardless of the point of entry (e.g., Medicare confidential compliance hotline, email, U.S. mail, etc.). Upon receipt of any compliance or FWA complaint, the Medicare Compliance Department logs the complaint and forwards it to the Medicare Compliance Officer or his/her designee, who initiates an investigation within two weeks of receipt of the reported potential violation. Depending on the type of reported activity, the Medicare Compliance Officer or his/her designee contacts all appropriate parties, such as relevant Molina staff or staff at FDRs, regulatory or law enforcement agencies, department supervisors and directors, executive staff, Molina General Counsel, Molina members, and the Human Resources Department. The Medicare Compliance Officer or his/her designee obtains all relevant data and documentation to investigate the allegation. Following analysis of all documentation, data, medical records, and interviews, the Medicare Compliance Officer or his/her designee determines the findings of the investigation, including whether the allegations of non-compliance or fraud, waste or abuse are confirmed. The Medicare Compliance Officer confers with Medicare Operations management to determine any corrective actions and/or sanctions to impose. In the case of employee issues, HR will also be involved in determining the appropriate disciplinary action, if any.

The Medicare Compliance Officer reports the results of all compliance and fraud, waste and abuse investigations to the Medicare Compliance Committee. The Compliance Officer also reports the actions taken with respect to corrective action measures, any disciplinary action and/or sanctions for non-compliance to the Medicare Compliance Committee.

Investigation results are communicated both verbally and in writing by the Medicare Compliance Officer or his/her designee to relevant parties, including individuals or entities against whom the allegation was made. The written communication includes the proposed disciplinary and/or corrective action plans for the detected offense as approved by the

Medicare Operations Management and Human Resources, as applicable, as well as timeframes for correction and a description of the method of evaluation to determine whether the violation has been corrected.

In the case of non-compliance and/or fraud, waste and abuse by an FDR, the corrective action plan developed by the Medicare Compliance Officer and approved by the Medicare Operations Management will be documented in a written agreement with the FDR. The agreement will provide details of the required corrective action, timeframes for completion of the corrective action, a description of the methods of evaluation to ensure the corrective action plan has been implemented and effective in correcting the violation, and a description of the ramifications to the FDR, should the entity fail to implement the corrective action according to the plan, or should the corrective action fail to correct the violation.

The Medicare Compliance Department maintains complete and thorough documentation of all investigations, including a description of the suspected non-compliance or fraud, waste or abuse, a description of the investigation, copies of relevant documents and notes from staff and other interviews, findings from the investigation, and disciplinary and/or corrective actions taken as a result of the investigation.

Referral of Non-Compliant Activities to Government Agencies and Law Enforcement

In the event that the investigation confirms non-compliant activity, the Medicare Compliance Officer reports the activity to the relevant government and/or law enforcement agencies, including but not limited to CMS and the Office of the Inspector General (OIG). Molina participates in and cooperates with investigations by such agencies as requested.

Referral of Potential Fraud, Waste and Abuse to the NBI MEDIC

In addition to the internal investigation of reports of potential fraud, waste and abuse, the Medicare Compliance Officer, or his/her designee refers potential fraud, waste and abuse cases to the applicable National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC) and/or federal and state entities as applicable. The Medicare Compliance Department maintains a log of all potential fraud case referrals to the NBI MEDIC and/or federal and state entities. In accordance with CMS guidance, the log includes the following, as applicable:

- Name of Molina Medicare Compliance Officer or SIU Investigator and Organization
- Contact information for follow up
- Summary of issue

- Any potential legal violations
- Specific Statutes and allegations
- Incidents and issues
- Background information
- Perspectives of Interested parties
- Data
- Recommendations in pursuing the case

The Medicare Compliance Department forwards all required documentation of the case to the NBI MEDIC as expeditiously as possible, but no later than 60 days after making a determination that potential instances of fraud, waste or abuse have occurred. If the NBI MEDIC requires additional information, the Medicare Compliance Department will obtain and provide the additional information within 30 days of the request from the MEDIC, unless the NBI MEDIC specifies otherwise.

Responding to CMS Issued Fraud Alerts

The Molina Medicare Compliance Officer or his/her designee is responsible for responding to CMS alerts concerning fraud schemes identified by law enforcement officials. These alerts describe alleged activities involving pharmacies practicing drug diversion or prescribers that participate in illegal remuneration schemes. Molina will take action (i.e. denying or reversing a claim) in instances where Molina's analysis of our claims activity determines that fraud may be occurring.

When CMS issues a fraud alert, the Medicare Compliance Officer or his/her designee will coordinate with the applicable Provider Contracting Department to review its contracts(s) and considers termination of a contract(s) if law enforcement has issued indictments against the identified parties and the contract authorizes contract termination.

The Molina Medicare Compliance Officer or his/her designee will submit past paid claims to Molina's Special Investigations Unit for review to identify claims that may have been part of an alleged fraud scheme. If claims are identified as being part of the fraud scheme, the Medicare Compliance Officer or his/her designee will coordinate with Molina's contracted Prescription Drug Benefit Manager (PBM), to remove the prescription claims from our sets of Prescription Drug Event Data (PDE) submissions.