Molina Medicare
FFY 2024 Fraud, Waste, and Abuse Plan

Table of Contents

Section 1

1.0 Introduction and Purpose

Molina Medicare is dedicated to the detection, prevention, investigation, and reporting of potential health care fraud, waste, and abuse. Accordingly, Molina 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, regulations, and guidelines:

- Applicable state laws and contractual requirements.
- Civil False Claims Act, 31 U.S.C. §§3729-3733
- Criminal False Claims Act, 18 U.S.C. §287
- Anti-Kickback Statute, 42 U.S.C. §1320a-7b
- 42 C.F.R. 422 and 423
- 1902(a)(68) of the Social Security Act
- Regulatory guidance produced by the Centers for Medicare and Medicaid Services (CMS), including requirements in Chapter 9 of the Medicare Prescription Drug Benefit Manual and Chapter 21 of the Medicare Managed Care Manual.

The FWA Plan has been developed to comply with all standards set forth by the regulations and laws of the United States Department of Health and Human Services CMS. The FWA Plan is reviewed periodically with revisions made as needed.

1.1 Definitions

Fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

Abuse includes actions that may, directly or indirectly, result in nnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically necessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other facts.

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

Molina's Medicare Compliance Officer is the individual within the organization who is responsible for ensuring the health plan is abiding by the FWA Plan. The Medicare Compliance Officer, along with the Special Investigation Unit (SIU), has the responsibility and authority to report all investigations resulting in a finding of possible acts of fraud, waste, and abuse by providers or members to the Medicare Drug Integrity Contractor (MEDIC).

Contact information for the Medicare Compliance Officer is as follows:

Rohit Gupta
Medicare Compliance Officer
Molina Medicare
200 Oceangate, Suite 100
Long Beach, CA 90802
Phone number: 1-562-951-1594,,,,,111594
E-Mail: rrohit.gupta2@molinahealthcare.com

1.3 Special Investigation Unit

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 the MDHHS. The Compliance Officer works in cooperation with the MEDIC and other state and federal regulatory and/or law enforcement agencies in investigations of suspected fraud, waste, and abuse as necessary. Molina provides copies of all records requested to the MEDIC or any authorized agent or federal entity.

Molina's SIU is led by the Vice President of Program Integrity, FWA Programs (VP-PI) who is responsible for SIU development, implementation, and together with two (2) AVP's of Special Investigations is responsible for oversight of daily activity and the administration of this anti-fraud plan. Contact information is as follows:

Scott Campbell, CFE
Vice President of Program Integrity, FWA Programs (VP-PI)
Molina Healthcare, Inc.
200 Oceangate, Suite 100
Long Beach, CA 90802
Phone number: ((562) 380-2879
E-mail: scott.campbell@molinahealthcare.com

The VP-PI serves under the SVP-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 AVP's of Special Investigations 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 VP-PI and AVP's of SIU oversee the following staff:

- **SIU Directors,** responsible for day-to-day operations and oversight of the SIU activities
- **SIU Manager**, dedicated solely to the Texas Medicaid and CHIP programs to direct oversight of the SIU and Fraud, Waste, and Abuse activities and is the single point of contact that can respond to calls and speak to all MCO FWA functions *including the SIU processes* and respond to inquiries related to Molina's handling of investigative activities, including for the referral and investigation functions. Reporting to the SIU Manager are Investigators and nurses whom process cases from end to end, and whom conduct medical records reviews as subject matter experts
- **SIU Manager (Coding)** 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 Manager (Intake and Reporting),** responsible for the oversight of all regulatory reporting and triage of the fraud tip line. Reporting to the supervisor are Analysts.
- **SIU Investigators**, who conduct 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.
- Additionally, SIU Data Analysts report to the VP-PI and are responsible for special data analytics projects assessing potential FWA.

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

Section 2

2.0 Education of Employees, Providers and Members

2.0.1 Employees[1]

Molina provides training for employees, to include the Medicare 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 address Molina's commitment to detecting, preventing and investigating fraud, waste, and abuse. The Code of Business Conduct and Ethics can be found in Molina Medicare's Compliance Plan and is supplied as Attachment B in this FWA Plan. The Code of Business Conduct and Ethics, the Medicare Compliance Plan, the FWA Plan, and Compliance policies and procedures are made available to all employees:

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

- All employees, including management, at the time of hire, annually thereafter, and when updated.
- All Molina Healthcare directors at the time of appointment to the Board, annually thereafter, and when updated.
- All contractors/vendors, including first-tier, downstream, and related entities at the time of contact signature, annually thereafter, and when updated.

The Code of Business Conduct and Ethics, the Medicare Compliance Plan, the FWA Plan, and Compliance policies and procedures are made available to all Molina Medicare employees, Board of Directors and directors via the Compliance intranet site. Molina Medicare Compliance ensures that at least annually, and upon material change, all Molina Medicare employees and directors are notified by email or other means of communications that the materials are posted to the Molina Medicare intranet site.

The Code of Conduct, the Medicare Compliance Plan, the FWA Plan, and Compliance policies and procedures are distributed to contractors/vendors via the Molina Medicare internet site. Molina Medicare Compliance ensures that at least annually, and upon material change, all contractors/vendors are notified by blast fax or other means of communication that the materials are posted to the Molina Medicare internet site.

In accordance with Molina's anti-fraud and Deficit Reduction Act policies, new employees, within 30 calendar days of employment, and existing employees on an annual basis must complete anti-fraud training delivered through the Learning Lab system. The fraud, waste, and abuse training reinforces and expands upon the fraud, waste, and abuse training provided to new employees during employee orientation. The fraud, waste, and abuse training addresses:

- The impact of fraud, waste, and abuse on healthcare.
- The definitions of fraud, waste, and abuse.
- The Deficit Reduction Act and Federal False Claims Act.
- The Anti-Kickback statute
- 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 the LearningLab. 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 Learning Lab in order to track compliance with Molina's training requirements. Training reports are maintained for a period of 10 years. Additional training logs are maintained for training delivered by compliance staff. These training logs include the name and title of the trainer, date time and location of training, subject matter and name of the employees attending the training.

Molina's 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.

2.0.2 Board of Directors

It is imperative that members of Molina Healthcare, Inc.'s Board of Directors are aware of and comply with all fraud, waste, and abuse requirements. Fraud, waste, and abuse training is mandatory for all Molina Healthcare, Inc. Board members. This training is conducted within 90 days of appointment to the Board and annually thereafter, on or around the first Board meeting of each year. Medicare Compliance is responsible for collecting documentation of attendance and training content.

2.0.3 Providers

Education on fraud, waste, and abuse is contained in Molina's Provider Manual. The provider manual includes information on the:

- Deficit Reduction Act
- False Claims Act
- Anti-Kickback statute
- Stark Statute
- Sarbanes-Oxley Act of 2002
- Fraud, Waste, and Abuse definitions.

And, provides:

- Examples of Fraud, Waste, and Abuse.
- Instructions for reporting suspected provider and member fraud and abuse to Molina.
- Prepayment Fraud, Waste, and Abuse detections activities.
- Post Payment Audit recoveries.

The provider manual is used as the basis for new provider orientations conducted by Provider Services. Information contained in the provider manual is also available to providers on Molina's internet site.

Section 3

3.0 Confidential Reporting of Suspected Fraud, Waste, and Abuse

Molina utilizes several mechanisms to encourage anonymous, confidential and private, good faith reporting of instances of suspected fraud, waste, and abuse. Molina maintains confidential reporting mechanisms that Molina employees, members, and providers can use to report suspected fraud, waste, and abuse. The Molina Healthcare AlertLine 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, any Compliance official, or the Legal department.

Molina trains all employees on the various reporting mechanisms during new employee orientation and thereafter on an annual basis. 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[2]	• 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.

[2] Anyone referring a potential fraud, waste, or abuse matter has the right to report matters in confidence, and if they choose, remain anonymous. Information reported will remain confidential to the extent possible as allowed by law.

Type of Information	Details Required
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?

Molina's commitment to employee training also includes access to Alertline reporting capabilities via Molina's Intranet site, The Hub. For remote employees, Molina's intranet landing page includes a dedicated single-touch icon which connects you directly to the compliance reporting system. An image of The Hub is included as Attachment C.

Molina's policy prohibits retaliatory acts by Molina 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

Molina uses various methods for preventing and detecting member, provider, and subcontractor fraud, waste, and abuse in the administration and delivery of services including, but not limited to, oral or written reports by providers, members, and employees. Additionally, Molina reviews provider contract status', deploys claims audits and analyses; institutes claims system edits and flags; uses profiling software analysis and reporting; and performs reviews and investigative audits of providers' billing practices and service patterns to prevent and detect potential fraud, waste, and abuse.

4.0.1 Credentialing and Licensure

The scope and structure of Molina's credentialing and re-credentialing process is consistent with recognized industry standards such as the National Committee for Quality Assurance (NCQA) and relevant state and federal regulations, including 42 C.F.R. §438.214(b), relating to credentialing of providers.

Initial credentialing is completed before the effective date of the initial contract with a provider and includes verification of application and a site visit (as applicable). The re-credentialing process occurs not less than every three years following initial credentialing to ensure program conformance with state standards and regulations. During this process, medical record reviews are done to ensure conformance with Molina and state standards. At minimum, the review includes provider performance data, as follows:

- Quality of care.
- Recipient complaints, appeals, and satisfaction surveys.
- Provider profiles.

4.0.2 Review of Providers

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

- Health and Human Services Office of Inspector General and General Services Administration exclusions lists.
- Review of license reports from the appropriate specialty board.

These checks are conducted on a monthly basis. If a match is found, the Credentialing Services staff will request copies of relevant information from the appropriate government entity. Upon receiving this information, the documents are presented to the Credentials Committee for review and action.

Molina does not knowingly issue payment to any provider excluded from state or federal programs.

4.0.3 Review of Employees

All Molina employees are checked against the federal LEIE by the Human Resources as part of the hiring process. In addition, monthly review of the LEIE is done by a Molina 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.

4.0.4 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 Molina Medicare 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 lookback is conducted over a period of 36 months, and records on investigative activities are retained for a period of 10 years.
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.

4.0.5 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.

4.0.6 Claims Data Analysis

SIU utilizes a robust data analytics tool to proactively review claims to identify statistical outliers within peer (specialty) groups and services/coding categories. Investigators utilize HCFS (HealthCare Fraud Shield), which employs approximately 1,800 algorithms to identify billing outliers and patterns, over- and underutilization, and other aberrant billing behavior trends. The system pulls information from multiple public data sources and historical databases that track known fraud perpetrators. HCFS allows the SIU to incorporate the following into our analytics:

• The integration of American Medical Association coding logic into the analytics to drive leads more informatively
• Alerts generation based on external data sources like the NPI Database, the OIG LEIE List, and State exclusion lists
• Use of a proprietary database that consists of a variety of data from external sources (for example, board sanctions, actions against licensed network Providers, and more)
• Links to social media
• Use of approximately 1,800 algorithms, some with thousands of iterations, to identify FWA anomalies across 100 different categories and approximately 150 specialties

• Monitoring GeoAccess tracking to review the distance between Providers, Members, and services.
• Data Matching / Trending
• Statistical analysis to enable peer-to-peer comparisons for cost, service type, and diagnosis type.

- **Dashboards:** Housed within the analytics tools, dashboards are utilized to look for trends and new categories identified as having increased as red flags.
- **Algorithms:** As part of various analytics activity, algorithms identify specific areas of focus that allow ranking and profiling into hierarchical percentiles of outlier or aberrant behavior. Individual risks are measured and tallied to rank Providers and Provider groups in terms of total risk exposure within the identified categories. The SIU continue to focus on reviews and perform investigations into aberrant billing behavior identified through the course of the analytic process.
- **Ad Hoc Reporting:** Utilizing an additional reporting tool (Power BI) the SIU runs queries against its data warehouse to identify outliers and trend Provider and Member information. Power BI templates allow Molina PIU staff to drill down to specific targets/parameters to easily vet leads. Claims data sets are fed from Molina's Enterprise Data Platform, which contains all claims billed/paid, allowing for the capability to conduct peer-to-peer analysis. Visualization charts allow staff to monitor billing trends and spike analysis. The tables are interactive and allow the user to drill down into details and model trends over time and across Providers, service codes, diagnoses, and more.

Example algorithms include (not an all-inclusive list):

- Application of CMS CCI rules identifying illogical pairings of codes
- Assessment of pharmaceutical rules evaluating opioid abuse, MME (morphine milligram equivalents), doctor shopping, drug shopping, duplication between J-Codes and NDCs, spikes in drug use
- Rules identifying age diagnosis conflicts, once in a lifetime procedure, gender specific treatments
- Assessments of highly abuses lab codes and lab provider billing patterns
- Rules to evaluate Residential Rehab Facilities, Substance Abuse Partial Hospital "PHP", and Substance Abuse Intensive Outpatient "IOP"
- 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
- Rules evaluating hospice claims to identify improper length of stay and improper discharges and transfers

- 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.
- Impossible days / time billed
- 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.

4.0.7 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:

- Surgical services unrelated to or inconsistent with diagnosis.
- 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.
- Surgical "payment split" percentage rules.
- 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.
- 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.
- Anesthesia performed where not indicated during medical/surgical procedure.
- Multiple procedure reduction rules.
- Surgical team, co-surgeon, and assistant rules.
- Professional and technical procedures – double billing.
- Claims paid for an amount greater than billed amount.
- Service date versus received date exceeds Molina's submission days.

4.0.8 Routine Validation of Data

Molina 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, fraud, waste, and abuse for claims already paid. Routine validation will also review for instances of providers who bill for services not rendered.

4.0.9 Review of Pharmacy Encounters

Molina uses fraud and abuse detection software to analyze pharmacy encounters to detect potential fraud, waste, and abuse. The analysis identifies possible overuse and/or abuse of psychotropic and/or controlled medications by members who are allegedly treated at least monthly by two or more physicians. In this analysis, a physician includes but is not limited to: psychiatrists, pain management specialists, anesthesiologists, and physical medicine and rehabilitation specialists.

Surveillance of our claims and encounters is the process where Molina systemically audits every paid, reversed, and rejected transaction. Detailed algorithms flag outliers for further review and validation by Molina's team of pharmacy data analysts. False negatives prompt refinement of the algorithm and Molina sends true errors to the PBM for confirmation and resolution. Molina requires that the PBM respond to these within one business day and any resolution is to be completed within 24 hrs. All human or systemic errors impacting at least one of Molina's members (enrollees) or providers or Molina's financials/compliance requires a written corrective action plan. Following are examples of algorithms utilized in pharmacy claim audits:

Indicator	Description
1. Formulary drug not paying - Validation of reject code 70	To ensure that covered items do not reject as non-formulary, claims are validated against our PDL/formulary data files. Claims for drugs on the PDL/formulary should not reject for "70 – Drug not covered" , else they are flagged.
2. Non-formulary drug paying–	To ensure non-covered items are not paid, all paid claims are validated against our PDL/formulary data files. If they are not on the PDL/formulary, they are flagged.
3. Prior Authorization (PA) drug paying without a PA – Validation of reject code 75	To ensure proper clinical review, claims requiring PA should not pay without the presence of an approved override. Claims for items that require PA that do not have a clinical override present should reject for "75 – PA Required" or else they are flagged.
4. Non-PA drug not paying	Claims for drugs do not require a PA authorization should not reject for "75 – PA Required" or else they are flagged.
5. Drug paying for greater than allowed quantity over time edit	To ensure member safety, claims quantity and days supply are validated against formulary utilization limits. Claims that pay for drugs that exceed the quantity over time edit are flagged.

Indicator	Description
6. Drug paying when member under minimum age edit	To ensure member safety, the member's date of birth is compared to the age minimum set by the FDA for the specific drug reviewed. Claims for members who do not meet the age minimum should reject or else they are flagged.
7. Drug paying when member over maximum age edit	To ensure member safety, the member's date of birth is compared to the age maximum set by the FDA for the specific drug reviewed. Claims for members who exceed the age maximum should reject or else they are flagged.
8. Drug paying when exceeding maximum quantity edit	To ensure member safety, claims quantity and days supply are validated against formulary utilization limits. Claims exceeding the maximum daily dose limit should reject or else they are flagged.
9. Drug paying with incorrect gender restriction edit	To ensure member safety, the gender code on the claim is validated against the gender restriction code on the formulary file. Claims where the gender does not match should reject or else they are flagged.
10. Drug with incorrect NCPDP rejection code	For each of the scenarios listed above, to ensure proper NCPDP reject code and messaging at the POS, claims reject codes and messaging are verified against the formulary and matched for compliance. Non-matched claims are flagged.
11. Drug paying with incorrect cost share	To ensure accuracy of member cost sharing responsibility, paid claims copay and deductible are validated against the contracted benefit design. Claims cost share should never exceed the indicated limits, else they are flagged.
12. DESI drugs paying inappropriately	To ensure member safety, DESI 5 and 6 drugs are not covered by Molina. To ensure these drugs are not paid for, all paid claims are validated against a list of known DESI 5 and 6 drugs. If there is a paid claim for a DESI 5 or 6 drug the claim will be flagged.
13. Prompt pay	To ensure prompt payment to providers, an algorithm is used to compare claims data against encounters data, any transaction with a paid date greater than the state's payment timeliness requirement is flagged.
14. Plan paid accuracy	Molina Healthcare validates pricing through contract language between Molina and its PBM CVS/Caremark; Molina confirms claims adjudication at the rates within our CVS/Caremark PBM Agreement through audits, which thereby are also reflected in point of sale claims as well

Annually, through a request for proposal (RFP) process, Molina selects an independent third-party auditor to review our PBM contract and validate the performance in five key areas: (1) discounts and fees, (2) rebates, (3) PDL/Formulary adherence (4) pass-through pricing, and (5) the PBM's retail pharmacy network agreement.

4.0.10 Member Services

Member Services employees are responsible for responding to questions and concerns from members. Members may provide Member Service employees with information regarding suspected provider or member health care fraud, waste, and abuse. Member Services will verify with members that they are not being billed for covered services. When an employee suspects potentially illegal activity, they shall document the instance and report it to Molina Medicare Compliance.

4.0.11 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 Molina Medicare Compliance.

UM, through the claims system has the capacity to run reports that may identify overutilization billing practices and assist in identifying suspect fraud, waste, and abuse. The claims system also identifies non-authorized services and benefits based on billing codes and diagnosis, which are forwarded to UM to ensure the service(s) meet medical necessity guidelines. Potential health care fraud, waste, and abuse detected by UM staff are submitted to Molina Medicare Compliance.

Section 5
5.0 Investigation of Potential Fraud, Waste, and Abuse

The SIU conducts objective 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. Cases referred to the SIU will be investigated timely, with not more than two weeks lapsing after the date the potential fraud, waste, or abuse was identified to begin the preliminary investigation process.

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.

5.0.1.1 Preliminary Investigation

Upon receipt of or identification of suspected provider fraud, waste, and abuse is communicated to the SIU, the SIU Triage team performs a preliminary assessment of allegation to determine if sufficient information is available to pursue an investigation. If not, and the tip is anonymous, and there is no way to gather further evidence, the tip is closed. If there is sufficient information, the SIU Triage team analyst builds an initial pre-case lead in the investigative case management system, reviews scores in fraud analytics system, prepares a risk assessment, and a preliminary investigation is initiated.
The preliminary investigation includes, but 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, Molina will document the findings of the preliminary review and close the investigation.

5.0.1.2 Extensive 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[3] and encounter data are requested.

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

C. The requested medical records and encounter data are reviewed. As part of this review, utilization and quality of care may be 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 coding review of the medical records against encounter data may 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. 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.

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

Failure of the provider to supply the records requested by Molina will result in the provider being reported to the MEDIC, via the HPMS portal, as refusing to supply records upon request. The SIU will seek overpayment recovery in these situations.

5.0.1.5 Extensive Investigation – Medical Records Review

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 Extensive Investigation – Medical Records Not Available for Review

In the event where a provider's medical record documentation is not available for review, the provider must complete an attestation that no medical records exist. Situations of this nature may be subject to monetary recovery as determined on a case-by-case basis.

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.

The preliminary investigation includes, but 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 Determination of Potential Fraud, Waste, or Abuse

If the SIU determines possible fraud, waste, or abuse has occurred, the SIU must report these findings and supporting documentation to Molina Medicare Compliance. Supporting documentation must include:

- Allegation
- Statutes/regulations violated or considered.
- Results of the investigation.
- Copies of program rules and regulations for the time period in question.
- Summary of any interviews conducted.
- Encounter data for the time period in question.
- All supporting documentation obtained as the result of the investigation.

5.0.4 Reporting to Appropriate Government Agencies

5.0.4.1 External Referral to the MEDIC

The SIU refers potential fraud, waste, and abuse cases to the MEDIC, via the HPMS portal, and/or federal and state entities as applicable. The SIU will complete the designated fields in the portal as required.

When involving provider aberrant utilization, the referral will include the number of complaints of fraud and abuse made that warranted preliminary investigation; and, for each complaint that warrants investigation provide: the provider's name and identification number, source of complaint, type of provider, nature of complaint, approximate dollars involved, and legal and administrative disposition of the case.

An expedited referral will be made to the MEDIC and/or federal and state entities as applicable when Molina has reason to believe the delay may result in harm or death to patients, the loss, destruction, or alteration of valuable evidence; or a potential for significant monetary loss that may not be recoverable; or hindrance of an investigation or criminal prosecution of the alleged offense.

5.0.5 Deficit Reduction Act Section 6032 Health Care Entity Oversight

Molina shall comply with Section 6032 of the Deficit Reduction Act (DRA). Molina shall identify health care entities who it has paid $5 million or more in Medicaid funds and notify these entities of their obligation to abide by the DRA.

As of November 1st, of each calendar year, the health plan's Compliance department is responsible for identifying health care entities who were paid $5 million or more in Medicaid funds during the previous federal fiscal year (FY). The FY runs from October 1st through September 30th. Those

identified meeting this criterion will receive a notice via certified mail from the health plan requesting that the health care entity attest to compliance with Section 6032 of the DRA, which includes:

- Employee education regarding Medicaid fraud, waste, and abuse prevention and detection;
- Information in policies and procedures, to include the employee handbook, regarding:
    - The federal False Claims Act, and federal administrative remedies for false claims and statements;
    - State False Claims Act information;
    - Include as part of such policies and procedures detailed provisions for how the entity will detect and prevent fraud, waste, and abuse; and,
    - Include in any employee handbook the rights of employees to be protected as a whistleblower.

Health care entities will be directed to submit attestations to the health plan's Compliance Officer. Health care entities will have 30 calendar days to respond to the attestation request from Molina. The Compliance Officer shall report the status of attestations submissions to the Compliance Committee and the Compliance Committee shall monitor the process through to completion.

Section 6

6.0 Maintaining the Confidentiality of Member Information and Maintenance of Records

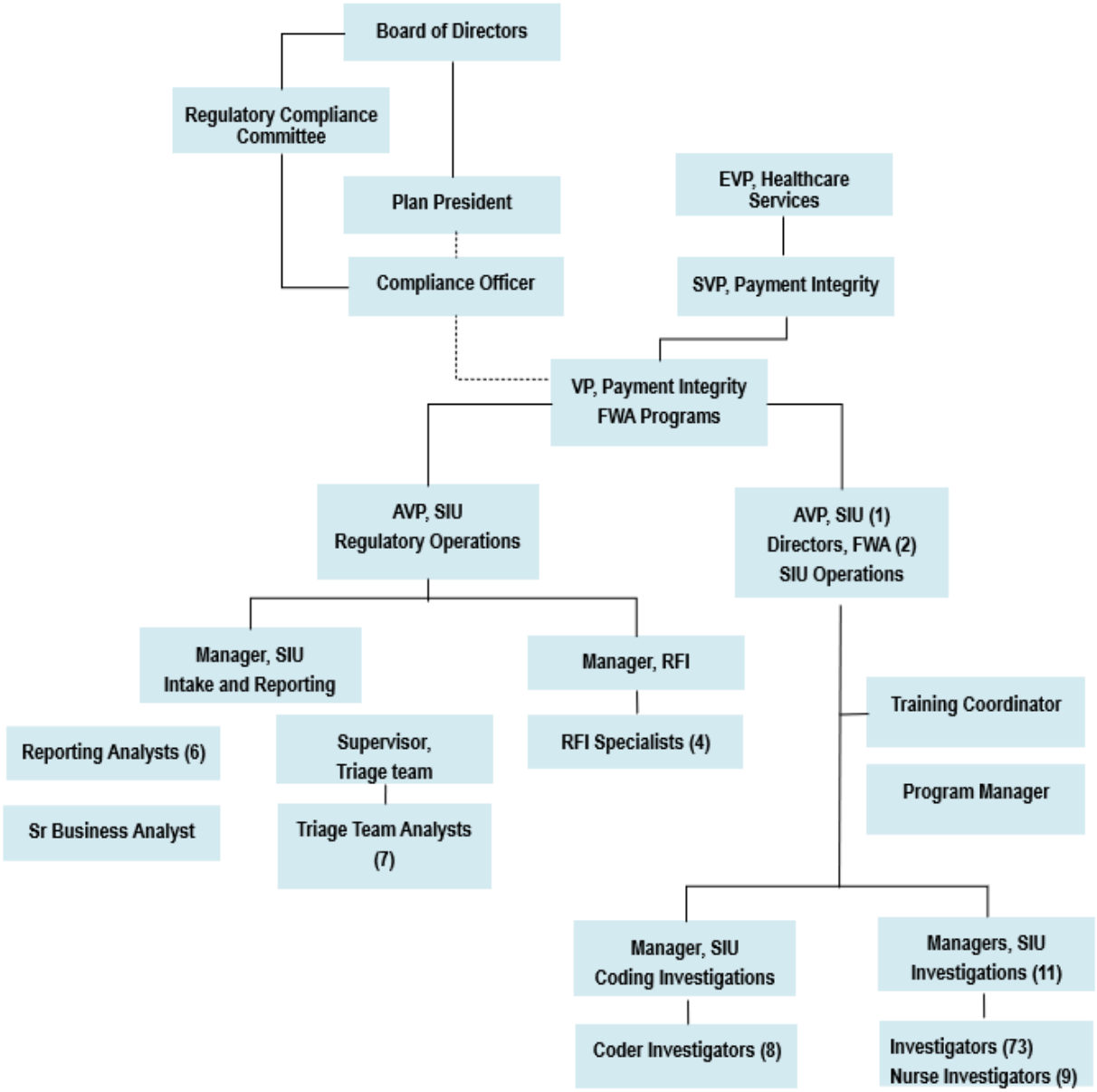
The SIU and Compliance maintain strict confidentiality of all reports, records, and investigations of suspected fraud, waste, and abuse. All reports of fraud, waste, and abuse are maintained on an internal log. The log records the subject of the report, the source, the allegation, the date the allegation 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 Members, legal staff, and designated management staff. Confidentiality abides by state and federal law.

Molina will retain records obtained as the result of an investigation conducted by the SIU for a minimum period of 10 years.

ATTACHMENTS

ATTACHMENT A

Special Investigation Unit



ATTACHMENT B

Introduction

This Code has been approved by the board of directors of Molina, and is applicable to all our employees, directors, officers, providers, contractors and subcontractors. Its purpose is to guide Molina's affairs and detail the way we conduct our business. It's our expectation that we conduct business in accordance with applicable laws, rules, contract requirements and always engage in ethical business and professional practices. Whenever the Code mentions an "employee," that usage should be interpreted to include an employee, director, or officer of Molina. Furthermore, whenever the Code refers to a "subcontractor," that usage should be interpreted to include a contractor, subcontractor, vendor, or any other Molina stakeholder.

As a condition of employment, all employees are required to acknowledge their receipt and understanding of this Code when they are hired and annually thereafter. Additionally, employees are required to complete a conflict-of-interest disclosure when they are hired, annually thereafter and at any time a potential conflict of interest arises. 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, might be subject to disciplinary action, including termination. Additionally, violating this Code might 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 might also be subject to disciplinary action, including termination.

Molina's Code is reviewed at least annually and updated as necessary to reflect alignment with state and federal requirements; key compliance, privacy and security issues, emerging risks, and/or best practices; and employee relations and environmental, social and governance matters, including diversity, equity, and inclusion.

Molina is committed to ethical practices and compliance with applicable laws and regulations that govern all areas of our operations, including business functions executed or supported by subcontractors. These business partners must match the expectations set forth here and in our separate Supplier/Third-Party Code of Conduct, which is accessible on Molina's public website. Nothing in this Code prevents you from communicating directly with relevant government authorities about potential violations of law.

Molina's 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.

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

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

Our Values - Integrity always, Absolute Accountability, Supportive teamwork, Honest and open Communication, Member and community focused.

Diversity, Equity, and Inclusion and equal employment opportunities
Molina is committed to creating an inclusive workforce that represents diversity of thought and experience – one that is equitable and fosters inclusive behaviors.
We embrace and celebrate the unique experiences, perspectives, and cultural backgrounds that each employee brings to our workplace because it makes us a stronger organization. Molina employees are expected to always treat others with dignity and respect, to exhibit inclusive behaviors and not exclude others on the basis of diverse beliefs or characteristics.
Employees who have witnessed or experienced behavior that conflicts with the Diversity, Equity, and Inclusion (DEI) policy or the Equal Employment and Anti- discrimination policy should promptly contact their supervisor or human resources.

Integrity and ethics
Our success depends on our ability to 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 always do the right thing. This Code can be used as an ethical compass. Employees have an obligation to behave professionally, and not engage in any disruptive behavior. Additionally, employees have an obligation to submit accurate records related to their job responsibilities.
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, but we must also adhere to ethical principles when performing work on behalf of Molina.

Accountability
Every employee and subcontractor must comply with the business processes, policies and standards established in this Code. Employees and subcontractors are expected to always follow the Code. Any perceived violation, misconduct and/ or non-compliance with Molina business processes, policies, and standards, including fraud, waste and abuse, must be reported immediately to a manager, compliance officer or via the Alertline by calling (866) 606-3889 or by filing a report online at MolinaHealthcare.Alertline.com.
If there is ever any doubt about 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 our legal department. Subcontractors should reach out to their designated Molina contact.
Nothing in this Code prevents you from communicating directly with relevant government authorities about potential violations of law.

EMPLOYEE RIGHTS, RESPONSIBILITIES AND DUTIES

Completion of mandatory training
We expect our employees to deliver high-quality services to our many stakeholders and follow all the rules and regulations that govern our business while they do it. Our employees are

provided with training on several important topics upon hire, including but not limited to this Code, our Compliance Program and its policies and procedures, and fraud, waste, and abuse. Our employees must complete refresher training annually thereafter. From time to time, additional or updated information must be provided to our employees in real-time, often as the result of rule or law changes, developments within our organization or current events. In these instances, training is created or updated and rolled out to our team as soon as possible. Employees who fail to complete their required trainings on time may be subject to disciplinary action, up to and including termination.

Duty to report

Our employees and subcontractors are the first line of defense in addressing any suspected wrongdoing. This means that it's our duty to report suspected non-compliance 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 is practical to an immediate supervisor, manager, human resources, compliance officer or our legal department. The employee or subcontractor can 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 non-compliant 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. Nothing in this Code prevents you from communicating directly with relevant government authorities about potential violations of law.

Retaliation

Molina's Equal Employment and Anti-Discrimination policy explains that retaliation is an improper and adverse action an employer might take, such as acts motivated by revenge, reprisal, retribution or" getting back" at someone for engaging in a protected activity, such as the reporting of observed or perceived misconduct or noncompliance; opposing an unlawful practice; or participating in a lawful investigation or proceeding. Our employees and subcontractors have a duty to make good-faith reports of suspected wrongdoing and/or non-compliance and cooperate with investigations.
Good-faith reports are those that are made to the best of a person's ability and knowledge and relate to facts that are believed by the person to be true. Good-faith reports are made without ill will or personal benefit. Molina makes a reasonable effort to protect the identity of the reporter or any inquiry or report we receive. 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, discrimination and/or humiliation from supervisors and/or co-workers; promotion restrictions; negative or targeted coaching or evaluations and heavy-handed monitoring that peers do not experience without just cause.

Retaliation can occur in many ways, none of which are tolerated by Molina. It's everyone's job to report potential non-compliance, unethical dealings, or other actions, and cooperate in investigations. We do not retaliate against anyone for doing their job.

Audits, investigations and court proceedings

All employees and subcontractors must be honest and forthright in their work and interactions with their coworkers and our stakeholders. All employees and subcontractors will fully cooperate with any internal or external audit, review, or investigation. All employees and subcontractors 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 our 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

Workforce members (employees, subcontractors, temporary staff, trainees, and interns) must be respectful to our employees, members, providers, regulators, community partners and competitors. Disrespectful behavior such as taking 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 must be reported. Failing to meet this standard might result in disciplinary action, including termination.

RESPONSIBILITIES OF EXECUTIVES AND MANAGEMENT

Molina has high expectations of its leaders. As a Molina leader, you must set a personal example of high ethical standards in your daily work. These requirements apply to all executive and management teams, including the board of directors, chief executive officer and other senior leaders and 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, the letter and spirit of the following statement:

> *Each executive and member of management 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, indirect, potential, or 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, within his or her areas of responsibility, to provide full, accurate, timely and understandable disclosure in reports and documents that the Company files with or submits to regulatory agencies. Additionally, each executive is expected to provide full, accurate and understandable information whenever communicating with Molina's stockholders or the general public.

CONFLICT OF INTEREST

Molina's Conflict of Interest policy explains that a conflict of interest exists when:

- An employee's duty to act in the Company's best interests is or can be compromised by actual, potential, or perceived benefit to that employee from another source; or
- An employee uses their position with Molina for personal financial gain or an employee's decision-making is, or could reasonably be, influenced by the promise of, or potential for, personal gain.

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, an issue might arise 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 have a duty to avoid business, financial or other direct or indirect interests or relationships that conflict with Molina's interests, or where such conflicts do arise, to fully disclose and monitor them. Examples of a conflict of interest might include certain personal relationships; outside employment; involvement in community organizations with which Molina collaborates; acceptance of gifts, hospitality and rewards from contractors, suppliers, organizations and people who make it difficult to avoid an obligation.

Because it's impossible to describe every actual, potential, or perceived conflict of interest, Molina relies on the commitment of its employees to exercise good judgment, seek advice from compliance, human resources, or our legal department when appropriate, and to adhere to the highest ethical standards in carrying out job responsibilities on behalf of the Company.

If an employee or a subcontractor wishes to engage in a transaction or activity that could potentially be in conflict with Molina's interests, the employee or subcontractor must disclose this information in writing as outlined in our 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

Gifts or rewards must be accepted with discretion, without affecting one's judgment or decision making. It's our 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 (e.g., goods, food, beverages, event invitations, tickets, etc.) that exceeds permissible values set forth in any Molina policy (e.g., Conflict of Interest policy, etc.).

ANTITRUST AND COMPETITION

Antitrust laws are complex and cover a broad range of conduct that might be illegal. In general, antitrust laws prohibit 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 standard-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 our legal 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 state and federal laws, and the highest industry standards, when applicable

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 United States (U.S.) Generally Accepted Accounting Principles (GAAP). Our records must be complete, 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's imperative we follow GAAP and other applicable laws.

Although intracompany 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 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 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 in all good faith 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/or imprisonment. Molina fully complies with all anti-money laundering laws and regulations.

Molina's reputation can be severely damaged by failing to detect transactions or relationships that put the Company and our members at risk. Employees and subcontractors are expected to be familiar with our 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 money laundering suspicions and activities.

COMPLIANCE AND FRAUD, WASTE AND ABUSE

Molina understands the importance of protecting and strengthening our members' health care resources. As such, we're dedicated to detecting and preventing fraud, waste, and abuse (FWA in government programs and our industry. Molina operates compliance and FWA programs that are designed to detect, prevent, and reduce FWA among its members, providers, employees and subcontractors.

False Claims Act

Under the False Claims Act (FCA), people and entities cannot knowingly submit a false or fraudulent claim for payment of U.S. government funds. In addition to what's considered traditional provider or member fraud, the FCA applies to claims made for payment to Medic Medicare and other government-sponsored health care programs by health care companies Molina. Potential fines for violating the FCA include:

- Up to three times the amount of the payment made on each false claim.
- Additional civil penalties for each false claim; and
- Payment of the cost of the civil action by the entity or person that submitted the false claim.

If found liable under the FCA, the Company or person may also be excluded or suspended from participating in all federal health care programs. They may also be required to serve time in
We are stewards of public funds. Employees and subcontractors are required to report all actual or suspected violations of the FCA, and all suspected, 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:

> *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))*

Anti-Kickback Statutes

Molina conducts all business in compliance with federal and state Anti-Kickback (AKB) statutes and regulations, and all federal and state marketing regulations.
AKB statutes and regulations prohibit paying or receiving anything of value to induce or reward patient referrals or the generation of business involving any item or service payable by federal and state health care programs. The phrase "anything of value" includes cash, discounts, gifts, excessive compensation, contracts not at fair market value, etc. Examples of prohibited AKB

actions include a health care provider who is compensated based on patient volume, or a provider who offers remuneration to patients to influence them to use their services.

Items of value and marketing requirements

Under Molina's policies, we cannot offer, solicit an offer, provide, or receive items of value of any kind that are intended to induce referrals of federal health care program business. The scope of this prohibition is far-reaching and can include things such as self-referrals by members in exchange for incentives, referrals to enroll in any of our products receiving federal or state funding and incentives to encourage providers to steer members to us. This rule covers many of our relationships with vendors, providers, brokers and potentially, even our members. The prohibition extends to money, gifts, entertainment, services, promises or anything else of value. Under our policies, we cannot give, offer, solicit, or receive anything of value to induce or attempt to induce referrals, or as a reward for referring a person to any person or entity to receive items or services paid for by a health care program (e.g., Medicare Advantage, state Medicaid and CHIP programs). The legal department should be consulted before offering, giving, soliciting, or receiving anything of value that is not a bona fide, fair market value payment for actual services or items provided. We must not, directly, or indirectly, make or offer items of value to any third party for the purposes of obtaining, retaining, or directing our business. This includes giving favors, preferential hiring, or anything of value to any government official.
Each of our health plans must conduct all marketing activities in accordance with the relevant contractual requirements and marketing statutes and regulations – both state and federal – that apply to the products offered in their state. Restricted marketing activities vary by state, but generally relate to the types and forms of communication that health plans, providers and others can have with members and prospective members. Examples of such communications include those related to enrolling members, member outreach and other types of communications. All marketing activities must be reviewed and approved according to Molina's policies and procedures to ensure they meet all our compliance requirements.

Privacy and security of information

Employees and subcontractors must protect the privacy and security of our confidential information and information about our members, and follow all applicable state, federal privacy and cybersecurity laws and regulations, including those associated with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended. Employees and subcontractors are required to follow our privacy and security policies and standards, and to report to any instances of non-compliance, including:

- Any unauthorized use or disclosure of protected health information. This must be immediately reported to Molina's privacy official by calling (866) 665-4629 or emailing HIPAAMailbox@MolinaHealthcare.com.
- Any cybersecurity event, such as an 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 our chief information security officer by calling (844) 821-1942 or emailing CyberIncidentReporting@MolinaHealthcare.com.

Protecting confidential information
All employees and subcontractors are expected to protect Molina's confidential information, including trade secrets. Our 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 our proprietary information confidential unless they're authorized to disclose such details. Employees must also refrain from disclosing any competitors' proprietary information. Employees should refer to our confidentiality policy for more information.

Insider trading
Molina employees and subcontractors cannot use or disclose non-public 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.

Protecting Molina's assets
Molina has a variety of assets, and many of them are 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 our assets include:

- Credit cards, cash and checks
- Buildings and fixtures
- Computers, hardware and software
- Office supplies
- Fax and copy machines
- Sensitive documents, information, data and records
- Telephones and voicemail systems
- Email, intranet and internet access

Each employee or subcontractor is responsible for protecting the Molina property assigned to them and for helping protect our assets in general. Upon termination of employment or contractual relationship with Molina, employees and subcontractors must immediately return any Company 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 our assets, you must report this immediately to your supervisor, manager, another member of the leadership team, local compliance officer or the chief compliance officer. Employees should refer to the Use of Company Assets policy for more information.

What is the difference between proprietary information and confidential information?
Proprietary information is any information that has been created by Molina or for Molina's use and gives us a competitive advantage. Our policies, standards, and procedures, as well as

operational processes are examples of proprietary information. Confidential information is meant to be kept secret or held within a small number of specific people. Protected health information (PHI); personally identifiable information (PII); employee personal information; provider tax identification (ID) numbers; provider credentialing records and proprietary information are examples of confidential information.

Proprietary information is usually confidential. This is information that isn't shared with people outside of Molina. It includes, business, financial and marketing plans associated with our services, know-hows and processes, business plans, personnel and salary information, patient information and copyright material connected with our services.

Employees and subcontractors must not use nor disclose our proprietary information, except as approved by Molina. Similarly, employees and subcontractors are prohibited from stealing the confidential or proprietary information of our competitors.

Unintended disclosure of proprietary or confidential information by employees and subcontractors can also harm our interests. Employees and subcontractors should not discuss confidential information, even with approved people within Molina, when in the general presence of others (e.g., 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 might be pieced together with fragments from other sources to form a complete picture. Additionally, this information should not be discussed with people within Molina who are not approved to receive such information.

If questioned by someone outside the Company about our confidential information, employees and subcontractors must not answer unless they have received approval to do so. People without approval to disclose such information must refer the inquiring party to the appropriate Molina compliance officer.

If a person retires or leaves the Company, they cannot disclose or misuse any of our confidential information. They must also return any such information to Molina. Furthermore, our ownership of intellectual property created by that person while an employee continues after they have left Molina.

The requirements to not share confidential and proprietary information includes posting this sort of information on social media.

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 people are authorized to share Molina's position publicly. Employees and subcontractors should ensure that any opinion or position they share as a person or entity does not give the appearance of speaking nor acting on Molina's behalf, unless specifically approved by the Company to do so in advance, and in writing. The responsibility of speaking on behalf of the Company is reserved for Molina's chief executive officer and colleagues in our corporate communications or investor relations departments. Unauthorized employees shall not provide information on behalf of the Company or act as spokespersons for Molina.

Persons with knowledge of an unauthorized employee potentially speaking on behalf of Molina should report this information with all applicable details to the Alertline by calling (866) 606-3889 or filing a report online at MolinaHealthcare.Alertline.com.

Nothing in this Code prevents you from communicating directly with relevant government authorities about potential violations of law.

INTERACTING WITH THE MEDIA

Molina employees cannot speak to the media on the Company's behalf without first coordinating with our communications team. Molina will respond to the news media 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, TikTok, etc.

Only designated staff within Molina's social media teams are permitted to create or post content on Molina social media platforms.

Molina's Social Media policy doesn't prohibit employees or subcontractors from using social media in their personal lives if the content being shared doesn't 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 and provider privacy and security, as well as other confidential proprietary information discussed in this Code, apply to social media, even within personal profiles. Employees are encouraged to refer to our social media policy or contact their compliance officer or the human resources department for further guidance.

Employees and subcontractors shall always protect the privacy and security, including cybersecurity, of our members and follow all applicable HIPAA rules and regulations.

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 Alertline at (866) 606-3889 or file a report online at MolinaHealthcare.Alertline.com.
- Subcontractors are encouraged to contact their designated Molina contact or relevant compliance officer or chief compliance officer.
- Nothing in this Code prevents you from communicating directly with relevant government authorities about potential violations of law.

FACILITIES, ENVIRONMENT, HEALTH AND SAFETY

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

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 Company property, while on duty or while operating a vehicle or potentially dangerous equipment leased or owned by

Molina. Additionally, employees are prohibited from any unauthorized removal of Molina property. For further guidance, please review our housekeeping and other facilities policies.

DISCRIMINATION AND HARASSMENT

Molina's Equal Employment and Anti-discrimination policy prohibits any kind of discrimination and harassment 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, including 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 they are being, or has been, harassed, discriminated or retaliated against should report the issue to their supervisor, manager, department leader or, if preferred, 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.

HUMAN RIGHTS

Molina recognizes the importance of maintaining and promoting the fundamental human rights of employees and subcontractors by operating under programs and policies that:

- Promote a workplace free of discrimination and harassment;
- Prohibit child labor, forced labor and human trafficking;
- Provide fair and equitable wages and benefits in accordance with local laws;
- Provide safe working conditions; and
- Recognize employees' rights to freedom of association.

Molina has zero tolerance for human rights violations.

INVESTIGATIONS INTO AN ALLEGED VIOLATION OF THIS CODE

Once a report of an alleged violation of this Code is received, members of Molina's team 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 information gathered, as well as the credibility of witnesses. 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 Molina's workforce. If anyone – employees, members, providers, subcontractors, directors or others – has a good-faith belief that a violation of this Code has occurred, or will occur, they are required to report it and cooperate with our investigation. 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, any of Molina's 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 Alertline at (866) 606-3889 or file a report online at MolinaHealthcare.Alertline.com, and must act in accordance with the guidance or advice they receive.
- Subcontractors are encouraged to contact their designated Molina contact or relevant compliance officer or chief compliance officer.
- Nothing in this Code prevents you from communicating directly with relevant government authorities about potential violations of law.

Attachment C

MOLINA HEALTHCARE

العربية Español Français (France) Hmoob Italiano Русский Tiếng Việt 繁體中文

Report Online | Report by Phone | Follow Up | Code of Business Conduct and Ethics | FAQs | Member Services

Molina Healthcare Alertline

Molina has partnered with NAVEX, an independent third-party provider, to offer a process for confidential reporting of suspected concerns regarding non-compliance by members, providers, and employees including - potential fraud, waste or abuse, Health Insurance Portability and Accountability Act (HIPAA privacy rules) incidents, company policy violations, unfair treatment in the workplace or other instances without the fear of retaliation.

Integrity and Ethics

Integrity Always is a core value at Molina. It is essential to our organizational success and mission that we always do the right thing. We expect all employees, subcontractors and representatives of our company to serve our valuable internal and external stakeholders with the utmost integrity and in an ethical and compliant manner.

Absolute Accountability

Understanding that compliance is everyone's responsibility as well as the obligation to speak up, helps the organization to foster an environment of honest and open communication, safety and trust in accordance with our Code of Business Conduct and Ethics.

REPORT ONLINE

REPORT BY PHONE

Alertline case submissions include:

- Non-compliance with Federal and/or State laws
- Provider billing for services you didn't receive
- A member allowing an unauthorized person to use their benefits
- Unauthorized disclosure of personal health information
- An employee or company representative violating the code of conduct or company policy
- Perceived retaliation from a manager