Molina Compliance Program

Revised February 3, 2020 by Molina Corporate Compliance

Molina Compliance Program Introduction

Goals and Components of the Molina Compliance Program

The Molina 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 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 Compliance Program which is comprised of the following key components:

1. **The Molina Healthcare Code of Business Conduct and Ethics** conveys Molina's commitment to and helps foster a culture of ethics and compliance that is 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 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 and as described in the Department of Justice (DOJ) Corporate Compliance Program Guidance.

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 Compliance and FWA Plan.

Applicability

At Molina Healthcare, Inc., Medicare Administration Management and Compliance are centralized and are largely performed by Molina Healthcare, Inc. employees. The Molina 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 2020, these legal entities consist of the following in alphabetical order:

- Molina Healthcare, Inc.
- Molina Healthcare of California
- 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
- Molina Healthcare of Texas, Inc.
- Molina Healthcare of Utah, Inc. (also dba Molina Healthcare of Idaho)
- 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 a Code with respect to the business conduct and practices governing the affairs of Molina Healthcare, Inc. (the "Company"). This Code governs the way 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.

Molina's Code of Business Conduct can be found on Molina's Website in the Health Care Professional Section under Medicare Compliance Program Documents.

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

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

Elements of the Molina Compliance and FWA Plan

The Molina 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 Compliance Program (the third is the Molina 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 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 Compliance Program. Additionally, these policies and procedures provide guidance on dealing with potential employee issues, identifies how to

communicate compliance issues to the Molina 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 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 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 Administration conducts a similar review of applicable operational policies and procedures and makes 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.

To promote an environment of open communication and reporting, Molina enforces a policy of non-retaliation and non-intimidation for good faith participation in the Molina 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 has a dedicated Compliance Officer who has primary responsibility for the day-to-day operation and oversight of the Medicare Compliance and the Fraud, Waste, and Abuse Programs. The Medicare Compliance Officer is responsible for the implementation of the Molina Compliance Program, 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 Compliance Program and continues to exercise reasonable oversight regarding the implementation and effectiveness of the program.

The Medicare Compliance Officer meets with the Senior Vice President responsible for Medicare Administration 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 Medicare Compliance Officer serves a consultative role to the Senior Vice-President of Medicare Administration. Although there is no direct line of authority to the Senior Vice-President of Medicare Administration, the Medicare Compliance Officer plays an important role with regard to informing the Senior Vice-President of Medicare Administration about compliance and FWA related issues that impact the ongoing operation of Molina Medicare products.

Responsibilities—Molina Compliance Department (MCD)

The Medicare Compliance Officer oversees the below listed staff:

Associate Vice President of Compliance – Internal/External Audits
Associate Vice President of Compliance – Corrective Action Plans
Associate Vice President of Compliance – Performance Monitoring and Reporting
Director of Compliance – Delegation Oversight
Director of Compliance – Risk Adjustment

The responsibilities of the Compliance Department include:

1. Overseeing and monitoring the implementation of the Molina Compliance Program.
2. Amending the Molina 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 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. Overseeing and evaluating the development and implementation of 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 Compliance Department and the Medicare Compliance Committee, including minutes of meetings, audit and monitoring reports, disciplinary action, investigations, disclosures, government inspections and training activities.
21. Ensures that Molina and its PBM review the Preclusion List on a regular basis and removes any precluded providers and pharmacies from the network as soon as possible.

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. Corporate Compliance
10. Finance
11. 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 Compliance Program.
5. Overseeing a system of internal controls to carry out the Molina 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 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 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 compliance and fraud, waste and abuse training programs are a condition of continued employment with the Company. Failure to comply with training requirements may result in disciplinary action.

The 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 are 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 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 Compliance and Fraud, Waste and Abuse Plan includes two different types of training:

Annual Compliance Training Curriculum

The Annual Compliance Training Curriculum includes, but is not limited to, the following topics:

- A review of the Molina Code of Business Conduct and Ethics, Molina Compliance and FWA Plan, and compliance policies and procedures;
- Review of applicable Federal and state laws and regulations, such as the False Claims Act, and the Anti-Kickback Statute.
- 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 expects its Medicare and Medicare-Medicaid Plan (MMP) FDRs to provide general compliance and Fraud, Waste and Abuse (FWA) training to its employees who perform critical roles such as those listed below:

- Vice President, Departmental Managers, Chief Medical or Pharmacy Officer);
- Individuals directly involved with establishing and administering Molina Healthcare's formulary and/or medical benefits coverage policies and procedures;
- Individuals involved with decision-making authority on behalf of Molina Healthcare (e.g. clinical decisions, coverage determinations, appeals and grievances, enrollment/disenrollment functions, processing of pharmacy or medical claims);
- Reviewers of beneficiary claims and services submitted for payment; or,
- Individuals with job functions that place the FDR in a position to commit significant noncompliance with CMS program requirements or health care FWA.

Delegated entity employees should complete both compliance and FWA training within 90 days of hire and annually thereafter. Molina delegated entities have the option to use any of the following materials for the training:

- Molina Compliance and FWA Information (included in the Provider Manual and public website)
- Centers for Medicare and Medicaid Services (CMS) training through the CMS Medicare Learning Network (MLN) at https://learner.mlnlms.com
- FDR internally developed training

To facilitate the oversight and monitoring for FDR compliance with the CMS and other federal and state regulators program requirements, laws, rules and regulations, annually, Molina requires its Medicare/MMP First Tier Entities to complete and sign an Attestation of Compliance Form. The attestations are maintained by the Molina 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 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 must 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. 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 website. Providers are informed of the confidential compliance hotline through the Provider Manual and the Molina 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 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 website.

Element 5: Well-Publicized Disciplinary Standards

For the Molina 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 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.

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 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 Compliance Department establishes and implements an effective system for routine monitoring and identification of compliance risks. The 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 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.

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 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 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 Compliance 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. 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 are 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 Compliance Department 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 and MMP 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 may be utilized by the Compliance Department 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 monthly 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 Compliance Department;
- the period 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 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 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 health plan Compliance Officer in preventing, detecting, investigating, and reporting all suspected, potential or confirmed fraud, waste, and abuse. 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.

In terms of Molina's SIU organizational arrangement, the Associate Vice President of Fraud Waste, and Abuse (AVP – FWA) is responsible for SIU development, implementation, and together with the Director Vendor Oversight and Operations are responsible for oversight of daily activity. Contact information is as follows:

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

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

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

- SIU Manager, who is responsible for referral intake and investigation functions. Reporting to the SIU Manager are the Analysts and Clerk.
- SIU Supervisor, who conducts oversight of the SIU Coding Analysts, who are responsible for conducting audits involving provider fraud, waste, and abuse related to coding and/or billing issues.
- SIU Clinician Manager who oversees the SIU Investigators, clinicians who are also responsible for conducting fraud, waste, and abuse audits related to clinical medical records.
- Additionally, SIU Data Analysts report to the AVP - FWA, and are responsible for special data analytics projects assessing potential FWA.

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 Compliance Department or the Special Investigations Unit (SIU), 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 during the investigation or to take corrective action.

All allegations of non-compliance and fraud, waste, or abuse are routed to the Compliance Department or the SIU respectively, regardless of the point of entry (e.g., Confidential compliance hotline, email, U.S. mail, etc.). Upon receipt of any compliance or FWA complaint, the Compliance Department forwards it to the Compliance Officer or his/her designee, or the SIU, 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, or the SIU, 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, or the SIU 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 or the SIU 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 Administration management or the SIU 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 or his/her designee, or the SIU 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 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 Administration 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 Administration 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 Compliance Department his/her designee, or the SIU 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 and/or the SIU 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, or the SIU, may refer 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 SIU will maintain a log of potential fraud cases referred 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 Compliance Department and/or the SIU 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 SIU 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, and the SIU, are 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 act (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 SIU, 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 SIU will review past paid claims to identify those that may have been part of an alleged fraud scheme. If claims are identified as being part of the fraud scheme, the SIU 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.