

Who is Required to Undergo Compliance and FWA Training?

Is my organization subject to compliance and FWA training requirements?

Molina Healthcare uses the criteria defined in the CMS Compliance Program Guidelines to determine whether a contracted entity is considered a First Tier, Downstream, or Related Entity (FDR) and therefore, subject to Compliance and FWA training requirements. Molina contacts all FDRs each year to request an attestation of training completion.

Some FDRs are deemed to have met the FWA training requirements through enrollment into Parts A or B of the Medicare program or through accreditation as a supplier of DMEPOS, and are exempt from completing FWA training. These FDRs, however, are NOT exempt from completing general compliance training.

Are all of my employees required to undergo compliance and FWA training?

There will be certain FDRs where not every employee needs to take the training based on their duties. Below are examples of the critical roles within an FDR that should clearly be required to fulfill the training requirements:

- Senior administrators or managers directly responsible for the FDR's contract with Molina Healthcare (e.g. Senior 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.

Which of my downstream contracted entities are subject to CMS training requirements?

CMS encourages discretion when developing the criteria for determining whether a contracted entity is to be considered an FDR (and therefore, subject to Compliance and FWA training requirements.) A list of factors is provided in the CMS Compliance Program Guidelines to determine if a contracted entity is an FDR, including, but not limited to:

- The function performed by the contracted entity, such as Utilization Management, Credentialing, Claims Processing, Sales and Marketing (this is not a complete list)
- To what extent the function directly impacts enrollees, and
- The decision-making authority of the contracted entity.

Definitions

First Tier Entity is any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program. (See, 42 C.F.R. § 423.501).

Downstream Entity is any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit or Part D benefit, below the level of the arrangement between an MAO or applicant or a Part D plan sponsor or applicant and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services. (See, 42 C.F.R. §, 423.501).

Related Entity means any entity that is related to an MAO or Part D sponsor by common ownership or control and

- (1) Performs some of the MAO or Part D plan sponsor's management functions under contract or delegation;
- (2) Furnishes services to Medicare enrollees under an oral or written agreement; or
- (3) Leases real property or sells materials to the MAO or Part D plan sponsor at a cost of more than \$2,500 during a contract period. (See, 42 C.F.R. §423.501).

Reporting Medicare Non-Compliance, and Fraud, Waste or Abuse

Molina Medicare contracted entities are required to report any potential issues of Medicare non-compliance or fraud, waste or abuse, within ten (10) days of discovery of the potential compliance issue.

In the event that the compliance issue has the potential to harm Molina Medicare members, the issue must be reported within one (1) working day of discovery.

Molina Medicare contracted entities may report issues through any of the following channels, though it is recommended to report compliance issues to the Medicare Compliance Officer via the Molina Healthcare Compliance Hotline:

- The contracted entity's staff person's immediate supervisor or manager;
- The contracted entity's Compliance Officer, if they have one; or
- The Molina Medicare Compliance Officer, via the Molina Healthcare Compliance Hotline

MOLINA HEALTHCARE COMPLIANCE HOTLINE:

Phone (toll-free 24/7 hotline): 1-866-606-3889

Web: <https://molinahealthcare.Alertline.com>

For more information, please refer to policy MMCD-05: Medicare Compliance Issues.

The Molina Medicare Compliance Program and supporting materials are available at www.molinahealthcare.com. Please select "Health Care Professionals" and then either "Medicare" or "Dual Options". Scroll down to the "Molina Compliance Program" or "Compliance Training" menu to make your selection.

MOLINA MEDICARE

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| Policy and Procedure No. MMCD-05 |
| Department: Compliance |
| Title: Medicare Compliance Issues |
| Effective Date March 1, 2011 |
| Reviewed and Revised Date: May 24, 2016 |
| Reviewed Only Date: |
| Supersedes and replaces: |
| Date: |

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|---|
| Name: John Tanner |
| Title: Medicare Compliance Officer |
| Signature:  |
| Date: 5/24/16 |

I. PURPOSE

To provide a process for Molina Medicare Compliance to fully and appropriately receive, document, investigate and resolve reports of potential or actual violations of Medicare or other federal laws, regulations, policy, and/or guidance, including unethical or non-compliant behavior.

Medicare compliance issues may be discovered at the corporate office level, the state health plan level, or at the level of Molina First Tier, Downstream, or Related entities (FDRs or “contractors”). Examples of compliance issues may include, but are not limited to:

- Theft, fraud, waste, and abuse
- Concern regarding accounting or auditing matters
- Accepting or offering remuneration in exchange for steering patients
- Improper use of Molina’s property and systems
- Falsifying documents
- Inaccurate or incomplete documentation and coding
- Non-compliance of regulatory requirements
- Unauthorized disclosure of PHI or confidential information
- Conflicts of Interest

II. POLICY

Molina Medicare employees and contractors are required to report any Medicare compliance concerns internally for investigation and follow-up by Molina Medicare Compliance. Molina does not retaliate, discriminate against, threaten or coerce any Molina employee or contractor who reports a case of potential or suspected non-compliance.

Molina Medicare Compliance documents and investigates all reports of potential non-compliance with Medicare and other federal statutory and regulatory requirements as well as policy guidance. Investigations are conducted timely and confidentially, and findings are communicated to the Medicare Compliance Committee, to Molina senior management, the Board of Directors, and when appropriate, certain government authorities. Corrective and/or disciplinary action is taken for confirmed cases of non-compliance.

III. PROCEDURE

A. Reporting Process—Molina Employees

1. Molina Medicare promotes and maintains an “open-door policy” at all levels of management to foster a work environment that enables Molina employees to report potential or suspected compliance concerns without fear of retaliation.
2. Molina Medicare Compliance informs employees, through the following methods, of the requirement to report compliance concerns and the reporting methods available:
 - i. FWA and Compliance training upon hire and annually thereafter;
 - ii. Distribution of the Medicare Compliance Plan upon hire and annually thereafter; and
 - iii. Compliance posters in various locations throughout corporate and state health plan facilities.
3. Molina Medicare employees are required to report any potential issues of Medicare non-compliance to the Medicare Compliance Officer, within ten (10) days of discovery of the potential compliance issue. In the event that the compliance issue has the potential for harm to Molina Medicare members, the issue must be reported within one (1) working day of discovery.
4. Molina Medicare employees are educated about Medicare requirements through annual Medicare training, which is provided for each functional area (e.g., enrollment/disenrollment, claims processing, appeals/grievances, organization/coverage determinations, sales and marketing, etc.), so that employees will be able to identify instances when Molina Medicare is out of compliance with Medicare requirements.
5. Molina Medicare employees may report issues of potential non-compliance through any of the following channels, though it is recommended to report compliance issues to the Medicare Compliance Officer or through the Medicare Compliance Hotline:
 - i. Their immediate supervisor or manager;
 - ii. The Human Resources Department;
 - iii. The Medicare Compliance Officer (via telephone, email, in writing, or in person);
 - iv. The Medicare Compliance Hotline and on-line reporting system, which are available 24 hours a day 7 days a week, 365 days a year:

B. Reporting Process—Contractors (First-Tier, Downstream, and Related Entities)

1. Molina Medicare, through the following channels, educates contractors of the requirement to report any cases of potential or suspected non-compliance to Molina Medicare and the reporting methods available:
 - i. The Molina Code of Business Conduct and Ethics, to which new contractors must sign a written attestation upon contracting and annually thereafter that they have received it, read it, and will comply;
 - ii. FWA and Compliance training upon contracting and annually thereafter.
 - iii. The Molina Medicare online provider portal
2. Molina Medicare contractors are required to report any potential issues of Medicare non-compliance to the Medicare Compliance Officer, within ten (10) days of discovery of the potential compliance issue. In the event that the compliance issue has the potential for harm to Molina Medicare members, the issue must be reported within one (1) working day of discovery.
3. Molina Medicare contractors may report issues of potential non-compliance through any of the following channels, though it is recommended to report compliance issues to the Molina Medicare Compliance Officer or through the Molina Compliance Hotline:
 - i. The contractor's immediate supervisor or manager;
 - ii. The contractor's Compliance Officer, if they have one;
 - iii. The Molina Medicare Compliance Officer (via telephone, email, in writing, or in person);
 - iv. The Medicare Compliance Hotline and on-line reporting system, which are available 24 hours a day 7 days a week, 365 days a year.

C. Confidentiality and Anonymity

1. The confidentiality of Molina employees and contractors who report compliance concerns, as well as those who are the subject of the allegation, is protected by the Medicare Compliance Officer and any other Molina Medicare staff that is assigned to investigate and/or follow up on the compliance concern to the greatest extent possible.
2. Any documentation related to the reporting and investigation of the compliance concern is kept in a confidential web-based tracking system accessible only by Molina Medicare Compliance.
3. If the reporting party wishes to provide an anonymous report of a compliance concern, they may submit the concern through the Medicare Compliance Hotline, without leaving their name or other identifying information. They may also report the compliance concern through the other methods described in III.A.5.i through iv (employees) or III.B.3.i through iv (contractors), requesting that the receiving party maintains their anonymity. The Medicare Compliance Officer informs the reporting party

that, as the investigation progresses, if CMS, the OIG or other government authorities become involved, they may ask to speak with the reporting party and that individual's identity may become known as part of the investigation.

D. Non-retaliation

1. Neither the Medicare Compliance Officer, nor any other Molina employee or contractor involved in the receipt, investigation, and/or follow up of a compliance concern, will intimidate, threaten, coerce, discriminate against, or take any other retaliatory action against any Molina Medicare employee or contractor who reports a compliance concern.
2. Molina Medicare Compliance informs the reporting party that he/she should report any retaliation to the Medicare Compliance Officer immediately if he/she becomes aware of any such action.
3. Any Molina Medicare employee or contractor who retaliates against a Molina employee or contractor who reports a compliance concern, or who refuses to participate in a violation of law, regulations, or policy is subject to Molina Medicare's disciplinary policy, up to and including termination of employment or contract.

E. Intake and Assignment

1. Acknowledgement. Molina Medicare Compliance acknowledges the receipt of the report and provides the reporting party with information regarding expectations of a timely response, confidentiality, non-retaliation, and progress reports.
2. Assignment. Molina Medicare Compliance leadership determines the appropriate department(s) and/or individual(s) whose involvement is required to investigate and/or resolve the issue:
 - i. If it is determined that the concern pertains to Fraud, Waste, or Abuse, the case is referred to the Special Investigations Unit for processing and resolution. Refer to the Medicare Compliance Fraud, Waste, and Abuse (FWA) Standard Operating Procedures.
 - ii. Non-FWA concerns regarding compliance with Medicare and other laws are assigned to Medicare Compliance staff for follow-up. Assignments are made with consideration to the areas of expertise of Compliance staff members. Medicare Compliance staff determines other business units to be included as needed to complete the investigation and resolution of the compliance issue.

- F. Documentation.** Molina Medicare Compliance maintains a confidential online database of all compliance issues received from any source that are related to Molina Medicare. Medicare Compliance staff review all reports of potential non-compliance and enter them into this database.

All documentation pertaining to the compliance issue is stored in this database. This documentation remains on file for a minimum of ten (10) years. Only Medicare Compliance staff may access the database and its contents.

- G. Investigation.** Medicare Compliance staff initiates an investigation within five (5) business days of receipt of the report.
1. **Interview—Individual reporting the event:** Medicare Compliance staff makes three attempts to contact the individual who made the initial report, either by phone, in person, or via email, to schedule and/or conduct an interview to determine the facts of the issue available to the individual who reported the issue. If Molina Medicare Compliance is unable to reach the person who made the initial report after three attempts, s/he notes that in the tracking system and obtains as much information as possible from other sources.
 2. **Interviews—other parties.** Medicare Compliance staff interviews all other parties who may have information related to the case, and documents the information in the tracking system.
 3. **Written documentation.** Medicare Compliance staff obtains and reviews any relevant written documents related to the case.
- H. Findings.** After interviewing all parties with information on the case (or making reasonable attempts to interview them), and gathering and reviewing all relevant and available documentation, Medicare Compliance staff presents the investigation findings to the Medicare Compliance Officer or his/her designee. The Medicare Compliance Officer or his/her designee makes a determination whether a violation of CMS or other federal law, regulation, policy or guidance exists. This determination may be made with input from other Molina senior management, such as the Vice President of Medicare, and the Senior Vice President responsible for Medicare.
- I. Reporting.** Compliance concerns are communicated to the Medicare Compliance Officer. The Medicare Compliance Officer reports compliance concerns to the Medicare Compliance Committee, Molina senior management, and the Compliance Committee of the Molina Healthcare Inc. Board of Directors.

If the Medicare Compliance Officer determines that the case should be forwarded to any government authorities for review, s/he will do so, following the process described in MMCD-13, Reporting Non-Compliance and FWA to Government Authorities.

- J. Resolution.** Molina Medicare Compliance resolves reports of compliance issues within 30 calendar days of receipt of the reported issue.

The Medicare Compliance Officer, in conjunction with the Vice President of Medicare, and the Senior Vice President responsible for Medicare, as necessary, determines whether the violation is subject to any or all of the following:

1. **The Molina disciplinary policy.** If so, the process described in MMCD-11, Medicare Disciplinary and Corrective Action Process—Employees or MMCD-12, Medicare Sanction Process—Contractors, is followed.
2. **Corrective actions.** If corrective actions are necessary and appropriate, the Medicare Compliance Officer or his/her designee develops a corrective action plan, in conjunction with functional area directors or other senior Molina management, when applicable.
 - i. The corrective action plan is tailored to address the problem at hand. A root cause analysis may be necessary to identify the cause of the problem.
 - ii. The corrective action plan includes timeframes for specific achievements by specific individual(s).
 - iii. The corrective action plan is discussed fully with the individual(s) to whom it applies, and the discussion is documented in the individuals' file, along with a signature and date of the individual(s) indicating agreement to comply with the corrective action plan.
 - iv. The Medicare Compliance Officer or his/her designee monitors the corrective action plan for the period of time stipulated in the plan.
 - v. At the conclusion of the corrective action period, the Medicare Compliance Officer or his/her designee evaluates whether the correction actions taken have effectively corrected the problem. If not, the Medicare Compliance Officer discusses the issue with the Medicare Compliance Committee to determine the next appropriate action to take.

Molina employees or contractors who report compliance concerns in good faith are not subject to Molina Medicare corrective/disciplinary action based on the act of reporting the compliance concern alone. Only when the Medicare Compliance Officer or his/her designee determines that the reporting party was involved in wrongdoing, or knowingly reported false information, is the reporting party subject to corrective/disciplinary action.

IV. REFERENCES

- 42 CFR §422.503(b)(4)(vi)(D)
- 42 CFR §423.504(b)(4)(vi)(D)
- 42 CFR §§ 422.503(b)(4)(vi)(G)
- 42 CFR §§ 423.504(b)(4)(vi)(G)
- CMS Medicare Managed Care Manual, Chapter 21, Section 50.4.2 and 50.7
- CMS Prescription Drug Benefit Manual, Chapter 9, Section 50.4.2 and 50.7
- CMS Program Audit Protocols, Compliance Program Effectiveness
- MMCD-10, Medicare Compliance Training Program
- MMCD-09, Medicare Compliance Officer
- MMCD-11, Medicare Disciplinary and Corrective Action Process—Employees
- MMCD-12, Medicare Sanction Process—Contractors
- MMCD-13, Reporting Non-Compliance and FWA to Government Authorities

- Medicare Compliance FWA Standard Operating Procedures



Molina Medicare
FFY 2015-2016 Fraud, Waste, and Abuse Plan

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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
- 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: unnecessary 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:

John Tanner
Medicare Compliance Officer
Molina Medicare
200 Oceangate, Suite 100
Long Beach, CA 90802
Phone number: 888-562-5442 Ext. 119091
Fax: (562) 901-1041
E-Mail: john.tanner@molinahealthcare.com

1.3 Special Investigation Unit

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

In terms of Molina's SIU organizational arrangement, the SIU Associate Vice President (AVP) is responsible for SIU development, implementation, and oversight. The SIU AVP serves as the subject matter expert regarding health care fraud, waste, and abuse. Along with developing and maintaining SIU systems and processes, the position is also responsible for providing leadership and direction regarding fraud, waste, and abuse to internal and external entities.

The SIU AVP oversees an SIU Manager, who is responsible for daily program operations. The SIU Manager oversees the SIU Supervisor, who conducts oversight of the SIU Coding Analysts who are responsible for conducting extensive investigations involving provider fraud, waste, and abuse. SIU Investigators, licensed nurses who perform medical review, report to the SIU Manager. The SIU Manager also oversees the SIU Specialists, who perform preliminary investigations and some extensive investigations involving members and providers.

SIU support staff includes a data analyst, who is responsible for conducting analysis in order to identify questionable outliers, an SIU Associate Specialist, who is responsible for certain administrative functions. An organizational chart depicting the SIU is included as Attachment A.

Section 2

2.0 Education of Employees, Providers and Members

2.0.1 Employees¹

Molina provides training for employees 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:

- 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 90 calendar days of employment, and existing employees on an annual basis must complete anti-fraud training delivered through the iLearn 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:

¹ Molina checks employees against exclusion lists prior to hire and monthly thereafter.
Medicare Compliance Committee Approved January 29, 2016

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

Compliance maintains electronic reports of employee training completed via iLearn 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.

2.0.4 First Tier, Downstream and Related Entities (FDR)

Molina requires fraud, waste, and abuse training within 90 days of contract signature and annually thereafter for FDRs. For annual fraud, waste, and abuse training, Molina Medicare Compliance contacts all FDRs each calendar year to have the FDR's submit completed attestations. Molina will accept evidence of fraud, waste and abuse training in the form of a signed attestation stating they have completed any one of the following trainings:

- Molina Fraud, Waste and Abuse Training
- Another Medicare Advantage Plans Fraud, Waste and Abuse Training
- Other training such as CMS Fraud Waste and Abuse training or the FDR's own Fraud, Waste and Abuse training

The attestation must be signed and dated and reflect the type of training they provided and the date of the training. The attestations are maintained by Molina Medicare Compliance. The Molina fraud, waste and abuse training, associated policies and attestations can be found on the Molina Medicare Website in the Provider section.

FDRs who have met the fraud, waste, and abuse certification requirements through enrollment into the Medicare program are deemed to have met the training requirements for fraud, waste, and abuse.

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:

- Complainant's Identity² - This should include the complainant's name, including alias or alternative names, address, phone numbers (e.g., work, home, & cell), email addresses, complainant or member's identification number (as applicable).
- Complainant's Relationship to Suspect – What is the relationship between the complainant and the reported suspect?
- Suspect's Identity – This should include the suspect's name, including any alias or alternative names, address, phone numbers (e.g., work, home, & cell), email addresses, suspect or member's identification number (as applicable).
- Witnesses – This should include the identity of all witnesses including names, any aliases or alternative names, addresses, phone numbers (e.g., work, home, & cell), email addresses, provider or member identification number (as applicable), and relationship to the suspect or complainant.
- Date(s) of Occurrence – When did the potential fraud, waste, and abuse happen? Provide dates and times.
- Allegation – A complete description of the allegation, including the type of fraud, waste, or abuse (e.g. balance billing, falsification of information, billing for services not rendered).

² Anyone referring a potential fraud, waste, or abuse 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.

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

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 related to the Molina Medicare contract, including but not limited to oral or written reports by providers, members, and employees. Additionally, Molina reviews provider contract status, employs claims audits and analysis, claims system edits and flags, profiling software analysis and reporting, and audits of providers' billing practices and service patterns to prevent and detect potential fraud, waste, and abuse.

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.
- Utilization Management, including overutilization and underutilization.
- Recipient complaints, appeals, and satisfaction surveys.
- Provider profiles.
- Medical Records Review for legibility, organization, completion, and program conformance including accessibility, availability, and content.

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 information is maintained 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

Molina uses analysis applications that regularly screen for the following:

- Emergency services that are not considered emergent.
- Readmissions or surgeries within 30 days of the original procedure for case management review.
- Claims submitted for Sundays and holidays (non-urgent or non-emergent).
- Services provided by a primary care physician (PCP) that is not the member's PCP of record.
- Providers' changing billing patterns and amounts for Current Procedural Terminology (CPT) codes that may indicate the provider may be fishing for maximum payment amount (improper billing).
- Durable Medical Equipment (DME) rental costs exceed the actual cost of the item.
- Excessive referrals to specific providers.
- Frequency of visits based on diagnosis.
- Medical bills show treatment on days immediately prior to member termination date.
- Provider frequently uses unusual codes.
- Psychological testing procedures and diagnosis.
- Referring doctor and medical provider belong to the same professional corporation (TIN) or share same address.
- Services with extended lengths of time.
- Services that reflect the most variation and frequency for a provider.
- Rural Health Clinics (RHC) and outpatient hospital utilization for the same services to identify any significant differences in utilization patterns.
- Profile therapy visits to identify providers billing consistently and whether the average number visits per member has increased.

- Profile frequency for specific tests, pharmacy, and additional dialysis sessions by member for End Stage Renal Dialysis (ESRD) claims.
- Identify patterns for home health agencies with similar demographics, such as frequency of visits, types of visits, visits per member, and lengths of stay.
- Diagnosis upcoding and multiple codes inconsistent to CPTs billed.
- Inconsistent findings between providers, such as anesthesia bill show one hour and hospital shows 1.5 hours.
- Provider changes codes for ongoing care.

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.

The following pharmacy claims are flagged for review:

- Quantity of prescriptions for a member is excessive.
- Multiple pharmacies are filling the same or a like prescription within 30-day period for a member.
- Multiple providers prescribing or administering the drug concurrently and the drug is being duplicated during the month.
- Duplicate prescription or prescription refills within 30-day period.
- Prescriptions for scheduled controlled substances for more than six weeks.
- Psychotropic and commonly sold drugs.

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

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

The preliminary investigation 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 records³ and encounter data are requested.
- C. The requested medical records and encounter data are reviewed. As part of this review, utilization and quality of care are assessed, sufficiency of the service data is validated, and the encounter data is reviewed for accuracy. Records are assessed for altering, falsification, and inappropriate destruction. Additionally, if the content of the records received is not sufficient to determine if fraud, waste, and abuse has occurred, then additional records may be requested as necessary to effectively conduct a review.

Based on this information received, a medical coding review of the medical records against encounter data will commence.

5.0.1.3 Additional Record Request (as Appropriate)

The SIU may request records from supporting providers to verify continuity in information for service procedures. 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.

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

- 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 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 and quality of care, a medical officer or other medical professional will sign-off on all 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. Review of acute care and emergency room claims submitted by providers for the suspected member.
- B. Analyze pharmacy claim data submitted by providers for the suspected member to determine possible abuse of controlled or non-controlled medications.

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 and/or federal and state entities as applicable. The SIU will complete the designated referral form, which contains all the data elements required by the MEDIC.

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.

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.

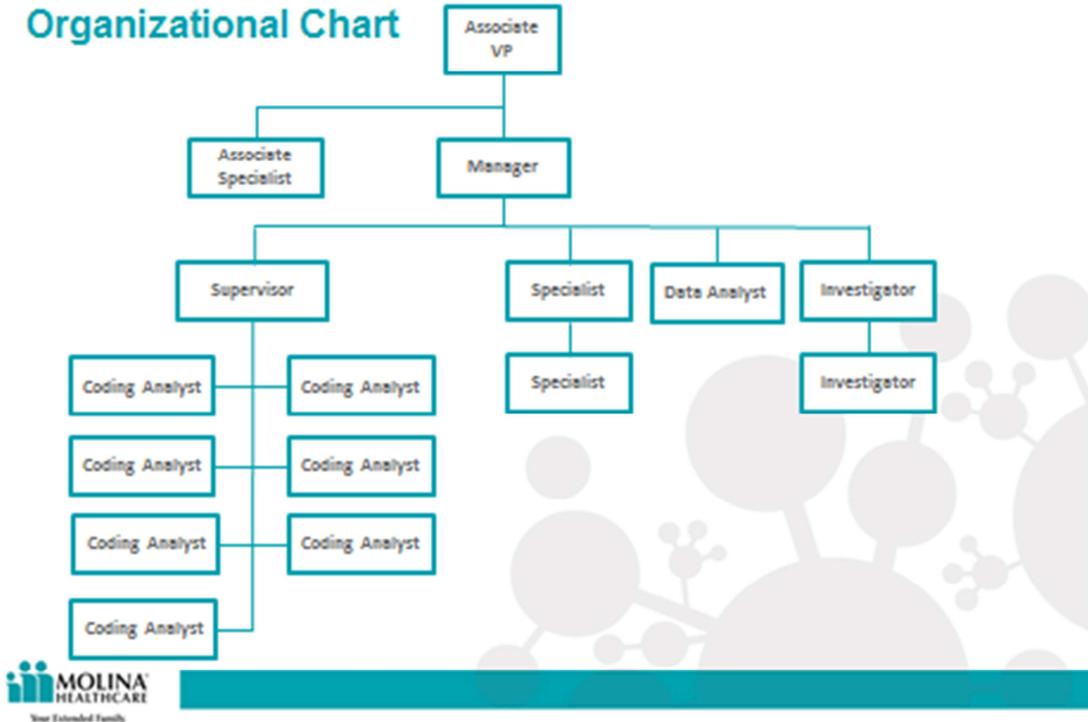
Molina will retain records obtained as the result of an investigation conducted by the SIU for a minimum period of 10 years.

ATTACHMENT A

Special Investigation Unit

Special Investigation Unit

Organizational Chart



ATTACHMENT B

MOLINA HEALTHCARE, INC. CODE OF BUSINESS CONDUCT AND ETHICS

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

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

Every employee, officer, and director, whose duties may include activity in areas covered by this Code, must be familiar with it and adhere to it at all times. Any employee, officer, or director in doubt about any aspect of this Code should contact his immediate supervisor or the Company’s General Counsel.

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

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

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

- 1.1 Provision of the Company’s services, and purchases of products and services or supplies, shall be made solely on the basis of quality, price, and service, and never on the basis of giving or receiving payments, gifts, entertainment, or favors.
- 1.2 No Company funds or assets shall be used for any unlawful purpose. No employee shall obtain privileges or special benefits through payment of bribes, illegal political contributions, or other illicit payments.
- 1.3 Employees owe a duty to the Company to advance the Company’s interest when the opportunity to do so arises. Employees are prohibited from:
 - a. Taking for themselves personally opportunities that are discovered through the use of Company property, information, or position;
 - b. Using Company property, information, or position for personal gain; and
 - c. Competing with the Company.

- 1.4 No undisclosed or unrecorded fund or asset shall be established for any purpose.
- 1.5 No false or artificial entry shall be made in the books and records of the Company for any reason, and no employee shall engage in any arrangement that results in such prohibited act, even if directed to do so by his or her supervisor.
- 1.6 All requests for payment shall be supported by a document stating the purpose for the payment. No payment shall be approved or made with the agreement or understanding that any part of such payment shall be used for any purpose other than that described by documents supporting the payment.
- 1.7 The Chief Accounting Officer shall have the primary responsibility to devise, establish, and maintain an effective system of internal accounting controls and to demonstrate that such controls are documented and periodically appraised.
- 1.8 The following activities are strictly prohibited by this Code:
- a. Offering, promising, or paying money or anything of value to any government employee or official, political party official, or any candidate for political office for any of the following purposes:
- Obtaining or retaining business for the Company;
 - Directing business to any person or entity;
 - Influencing any act or decision of such official in his or her official capacity;
 - Inducing such official to do or refrain from doing any act in violation of his or her lawful duty;
 - or
 - Inducing such official to use his or her influence improperly to affect or influence any act or decision.
- b. Causing, either directly or indirectly, an offer, promise, or payment as described above to be made through a third party or intermediary.

2. Conflicts of Interest

- 2.1 Every employee has a duty to avoid business, financial, or other direct or indirect interests or relationships that conflict with the interests of the Company or that divide his or her loyalty to the Company. Any activity that even appears to present such a conflict must be avoided or terminated unless, after seeking advice from the General Counsel, it is determined that the activity is not unlawful, harmful to the Company, or otherwise improper.
- 2.2 A conflict or the appearance of a conflict of interest may arise in many ways. For example, depending on the circumstances, the following may constitute a conflict of interest:
- Ownership of or an interest in a competitor or in a business with which the Company has or is contemplating a relationship (such as a provider, member, landlord, distributor, licensee/licensor, etc.), either directly or indirectly such as through family members.

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

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

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

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

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

a. Receiving Gifts and Hospitality:

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

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

b. Giving Gifts and Hospitality

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

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

3. Protecting the Company's Assets

- 3.1 The Company has a variety of assets, many of them of substantial value. They include but are not limited to physical things as well as proprietary information that may encompass intellectual property and confidential data. Protecting all these assets against loss, theft, and misuse is vitally important.
- 3.2 Each employee is responsible for protecting the Company's property entrusted to him or her and for helping to protect the Company's assets in general. Should you observe any situation that could lead to the loss, misuse, or theft of Company assets, you should report the situation to your supervisor as soon as possible.

4. Proprietary Information

- 4.1 Proprietary information is usually confidential. It includes, among other things, business, financial, marketing plans associated with the Company's services, know-how and processes, business plans, personnel and salary information, patient information, and copyright material associated with our services.
- 4.2 You must not use or disclose the Company's proprietary information except as authorized by the Company. Similarly, the Company's employees are prohibited from misappropriating the confidential or proprietary information of the Company's competitors.
- 4.3 Inadvertent disclosure by employees can also harm the Company's interest. You should not discuss confidential information even with authorized persons within the Company if you are in the general presence of others, i.e. at a trade show, reception, or in an airplane. Please keep in mind that harmful disclosure can start with the smallest leak, since bits of information may be pieced together with fragments from other sources to form a fairly complete picture. Further, you should not discuss such information with individuals within the Company who are not authorized to receive such information.
- 4.4 If questioned by someone from outside the Company about the Company's confidential information, do not attempt to answer unless you are certain you are authorized to do so. If you are not authorized, refer the person to the appropriate company officer.
- 4.5 If you retire or leave the Company, you may not disclose or misuse the Company's confidential information. Furthermore, the Company's ownership of intellectual property that you created while a Company employee continues after you leave the Company.

5. Compliance With Laws Governing our Business

The Company's business is subject to extensive regulation.

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

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

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

6. Speaking Out

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

7. Responsibilities of Employees

- 7.1 All employees are responsible for complying with this Code. Any employee having information concerning any prohibited act shall promptly report such matter to his or her supervisor or the Compliance Officer. The Company will not allow retaliation for reports made in good faith.
- 7.2 All employees are expected to provide full assistance and disclosure to the Company's internal and external auditors and lawyers in connection with any review of compliance with this Code.
- 7.3 All employees are expected to endeavor to deal fairly with the Company's regulators, providers, members, competitors, and employees. No employee should take unfair advantage of anyone through manipulation, concealment, abuse of privileged information, misrepresentation of relevant facts, or any other unfair dealing or practice.

8. Responsibilities of Executives

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

- 8.1 Each Executive will act at all times honestly and ethically, including the ethical handling of actual or apparent conflicts of interest between personal and professional relationships. For purposes of Section 8 of this Code, the phrase "actual or apparent conflict of interest" shall be broadly construed and include, for example, direct conflicts, indirect conflicts, potential conflicts, apparent conflicts, and any other personal, business, or professional relationship or dealing that has a reasonable possibility of creating even the mere appearance of impropriety.
- 8.2 Each Executive shall, within his or her areas of responsibility, cause to be taken reasonable and necessary steps to provide full, fair, accurate, timely, and understandable disclosure in reports and documents that the Company files with or submits to the Securities and Exchange Commission, and in all other regulatory filings. In addition, each Executive must provide full,

fair, accurate, and understandable information whenever communicating with the Company's stockholders or the general public.

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

9. Waivers

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

Attachment C



**COMPLIANCE
ALERTLINE**

1-866-606-3889
<https://molinahealthcare.AlertLine.com>

Do you have a compliance concern? The Compliance AlertLine allows you to voice your concern confidentially and ANONYMOUSLY, if you prefer.

-  **Purpose:** The purpose of the Compliance AlertLine is to provide an alternative method of reporting suspected or potential compliance issues of any federal or state laws, government or company policies.
-  **Hours:** The AlertLine is staffed by a third party vendor and is available 24 hours a day, 7 days a week and 365 days per year.
-  **Tell Us About:** Any concerns regarding fraud, waste and abuse, accounting or auditing matters, accepting or offering remuneration in exchange for steering patients, improper use of Molina's property and systems, falsifying documents, inaccurate or incomplete documentation and coding, non-compliance of regulatory requirements, unauthorized disclosure of protected health information (PHI) or confidential information, and conflicts of interest. This list does not include all of the possible violations that should be reported to the Compliance Department but provides examples of the different type of concerns that Compliance would like to hear about.
-  **Non-Retaliation:** If you prefer, you may also report any such concerns directly to a supervisor, compliance officer, or human resource representative without fear or retaliation, retribution or harassment for reporting the concern.

