Molina Healthcare of South Carolina Fraud, Waste & Abuse (FWA) Training

For Providers, Staff, and Contractors

2026 / Molina Healthcare of SC Provider Relations

MOLINA HEALTHCARE

Why FWA Training Matters

The Cost of Fraud:

- Medicaid fraud costs the U.S. **billions** annually — roughly **$100 million lost every day**.
- These losses reduce funds available for legitimate member care and vital health programs.

Impact on Care & Trust:

- Fraud, waste, and abuse drive up healthcare costs for everyone.
- It can lead to reduced access, lower quality of care, and diminished trust in the healthcare system.

Why FWA Training Matters

Your Role in Compliance:

- South Carolina Medicaid Managed Care regulations and Molina's compliance policies require annual FWA training.
- Training equips you to recognize red flags, prevent violations, and protect our members and organization.

Bottom Line:

- Every employee and provider plays a role in safeguarding program integrity, ensuring funds are used **for care — not crime**.

Your Role in Prevention

Your actions directly protect our members, our organization, and the integrity of the SC Medicaid program.

- **Follow Molina's Code of Conduct & Compliance Program**
  - Adhere to all ethical, legal, and professional standards.
  - Apply these guidelines in daily decision-making.
- **Report Suspected Violations Promptly**
  - Use designated reporting channels (Compliance Hotline, supervisor, or Compliance Officer).
  - Even if unsure, report concerns — early reporting can prevent larger issues.
- **Complete Annual Fraud, Waste & Abuse (FWA) Training**
  - Keep training up to date and document completion.
  - Review past training materials to stay aware of evolving rules and risks.
- **Remember:** Prevention starts with awareness, attention to detail, and speaking up when something doesn't seem right.

What is Healthcare Fraud?

- Fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any healthcare 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 healthcare benefit program.

- Fraud happens when someone knowingly tries to cheat a healthcare program- either by lying, making false claims, or using tricky schemes to get money or services that aren't entitle to. This isn't just a policy issue- it's actually a federal crime under U.S. law.

- USC § 1347

(a)Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice—

(1) to defraud any health care benefit program; or

(2) 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, in connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title or imprisoned not more than 10 years, or both. If the violation results in serious bodily injury (as defined in section 1365 of this title), such person shall be fined under this title or imprisoned not more than 20 years, or both; and if the violation results in death, such person shall be fined under this title or imprisoned for any term of years or for life, or both.

(b) With respect to violations of this section, a person need not have actual knowledge of this section or specific intent to commit a violation of this section.

Who is involved in Healthcare Fraud?

- Healthcare fraud isn't limited to just one group. It can be committed by anyone in the healthcare system – from providers and vendors to members and even employees. That's why everyone has a role to play in topping in.
- As a provider, you are responsible to have a strong compliance program including a well define anti-fraud plan to help detect, prevent and respond to fraud, waste, and abuse.

Examples of Healthcare Fraud?

- Submitting False Claims
- Kickbacks for referrals
- Prohibited Referrals
- Falsifying Medical records
- Unbundling and Upcoding
- Document Forgery
- Misrepresentation of Services
- Altering Audit Files

What is Abuse?

- Abuse happens when 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.
- Involves payments for items or services when there is no legal entitlement to that payment.
- While abuse may not always be intentional, it can still lead to serious consequences. The difference comes down to intent and awareness.
- Both can result in criminal, civil, or administrative penalties for providers.
- Examples:
  - Providing unnecessary services
  - Providing services that don't align with professionally recognized standards of care
  - Introducing unnecessary cost into the system.

What is Waste?

- Waste happens when healthcare services or resources are overused or misused, leading to unnecessary costs.
- It’s usually not criminal, but it can still result in:
  - Payments for services that aren’t medically necessary
  - Care that doesn’t meet professional standards

Key Federal & State Laws Protecting Medicaid Integrity

Why it matters that you know?

Understanding the key federal rules and state laws related to FWA is important for your role as a providers. Following them is not optional, it is critical. Not following these laws can lead to serious consequences, such as civil fines, criminal charges, or other penalties.

Key Federal & State Laws Protecting Medicaid Integrity

False Claims Act (FCA) 31 U.S.C. § § 3729-3733

- Anyone who knowingly submits or causes the submission of a false or fraudulent claim to the federal government can face civil liability.
- "Should have known", "knowing" or "knowingly" means deliberately ignoring or recklessly disregarding the truth. No specific intent to defraud is required.
- Penalties: $5,500–$11,000 per claim **plus** up to triple the damages.
- There also is a criminal FCA (18 U.S.C. § 287). Criminal penalties for submitting false claims include imprisonment and criminal fines. Physicians have gone to prison for submitting false health care claims.

Whistleblower Protections

- **What is a Whistleblower?**
  A person who reports suspected fraud, waste, or abuse — or other illegal or unethical activity — to the appropriate authorities.
- **Qui Tam Provisions (False Claims Act)**
- Allow private individuals to file lawsuits on behalf of the U.S. Government for false claims.
- **Potential Awards:** 15–30% of the total funds recovered.
- **Protections from Retaliation**
- It is illegal to fire, demote, harass, or otherwise retaliate against a whistleblower for making a good-faith report.
- Remedies include:
  - **Reinstatement** to the same or similar position
  - **Back Pay** for lost wages
  - **Compensation for damages** (emotional distress, attorney's fees, etc.)
- **Why This Matters to You**
- Encourages reporting of misconduct without fear of personal or professional harm.
- Supports a culture of integrity and compliance within Molina Healthcare and South Carolina Medicaid.

Key Federal & State Laws Protecting Medicaid Integrity

Anti-kickback Statute (AKS) 42 U.S.C. § 1320 a-7b(b)

- Criminal law that prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the Federal health care programs (e.g., drugs, supplies, or health care services for Medicare or Medicaid patients).
- Remuneration includes anything of value and can take many forms besides cash, such as free rent, expensive hotel stays and meals, and excessive compensation for medical directorships or consultancies.
- **In the Federal health care programs, paying for referrals is a crime.**
- Penalties:
  - Criminal penalties and administrative sanctions that includes fines, jail terms , and exclusion from participation in the Federal Care programs.
  - Under the Civil Monetary Penalties Laws, physicians who pay or accept kickbacks also face penalties of up to $50,000 per kickback plus three times the amount of the remuneration.
- Safe harbors protect certain payment and business practices that could otherwise implicate the AKS from criminal and civil prosecution.

Key Federal & State Laws Protecting Medicaid Integrity

Physician Self-Referral Law (Stark Law) 42 U.S.C. § 1395nn

- Prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies.
- Financial relationships include both ownership/investment interests and compensation arrangements.
- "Designated health services" are:
  - clinical laboratory services;
  - physical therapy, occupational therapy, and outpatient speech-language pathology services;
  - radiology and certain other imaging services;
  - radiation therapy services and supplies;
  - DME and supplies;
  - parenteral and enteral nutrients, equipment, and supplies;
  - prosthetics, orthotics, and prosthetic devices and supplies;
  - home health services;
  - outpatient prescription drugs; and
  - inpatient and outpatient hospital services.
- Proof of specific intent to violate the law is not required.
- Penalties for physicians who violate the Stark law include fines as well as exclusion from participation in the Federal health care programs.

Key Federal & State Laws Protecting Medicaid Integrity

Exclusion Statute 42 U.S.C. § 1320a-7

- Prohibits certain individuals or entities from participating in federal healthcare programs.
- Programs will no pay for any items or services provided, ordered, or prescribed by someone that is excluded.
- Exclusions are enforced by the Office of Inspector General (OIG) and the General Services Administration (GSA).
- You are responsible for ensuring that you do not employ or contract with excluded individuals or entities, whether in a physician practice, a clinic, or in any capacity or setting in which Federal health care programs may reimburse for the items or services furnished by those employees or contractors.

Key Federal & State Laws Protecting Medicaid Integrity

Civil Monetary Penalties Law (CMP) 42 U.S.C. § 1320a-7

- OIG may seek civil monetary penalties and sometimes exclusion for a wide variety of conduct and is authorized to seek different amounts of penalties and assessments based on the type of violation at issue. Penalties range from $10,000 to $50,000 per violation. Some examples of CMPL violations include:
  - presenting a claim that the person knows or should know is for an item or service that was not provided as claimed or is false or fraudulent;
  - presenting a claim that the person knows or should know is for an item or service for which payment may not be made;
  - violating the AKS;
  - violating Medicare assignment provisions;
  - violating the Medicare physician agreement;
  - providing false or misleading information expected to influence a decision to discharge;
  - failing to provide an adequate medical screening examination for patients who present to a hospital emergency department with an emergency medical condition or in labor; and
  - making false statements or misrepresentations on applications or contracts to participate in the Federal health care programs.

Key Federal & State Laws Protecting Medicaid Integrity

Medical Assistance Provider Fraud (SC False Claims Act) SC Code § 43-7-60

It is unlawful for a provider of medical assistance, goods, or services to knowingly and wilfully make or cause to be made a false claim, statement, or representation of a material fact:

> (1) in an application or request, including an electronic or computer generated claim, for a benefit, payment, or reimbursement from a state or federal agency which administers or assists in the administration of the state's medical assistance or Medicaid program; or
>
> (2) on a report, certificate, or similar document, including an electronic or computer generated claim, submitted to a state or federal agency which administers or assists in the administration of the state's Medicaid program in order for a provider or facility to qualify or remain qualified under the state's Medicaid program to provide assistance, goods, or services, or receive reimbursement, payment, or benefit for this assistance, goods, or services.

For purposes of this subsection, each false claim, representation, or statement constitutes a separate offense.

(C) It is unlawful for a provider of medical assistance, goods, or services knowingly and wilfully to conceal or fail to disclose any material fact, event, or transaction which affects the:

> (1) provider's initial or continued entitlement to payment, reimbursement, or benefits under the state's Medicaid plan; or
>
> (2) amount of payment, reimbursement, or benefit to which the provider may be entitled for services, goods, or assistance rendered.

For purposes of this subsection, each fact, event, or transaction concealed or not disclosed constitutes a separate offense.

(D) A person who violates the provisions of this section is guilty of medical assistance provider fraud, a Class A misdemeanor and, upon conviction, must be imprisoned not more than three years and fined not more than one thousand dollars for each offense.

Key Federal & State Laws Protecting Medicaid Integrity

Grounds for Sanction SC Regs. § 126-403

The grounds for sanctioning providers shall include, but not be limited to, the following:

A. Presenting or causing to be presented for payment any false or fraudulent claim for services or merchandise.

B. Submitting or causing to be submitted false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled, including charges in excess of the fee schedule or usual and customary charges.

C. Submitting or causing to be submitted false information for the purpose of meeting prior authorization requirements.

D. Failure to disclose or make available to the Single State Agency or its authorized agent records of services provided to Medicaid beneficiaries and records of payment made therefore.

E. Continuing a course of conduct deemed abusive of the Medicaid Program after receiving written notice from the Single State Agency that said conduct must cease, provided that the written notice shall specify the practices deemed abusive.

F. Breach of the terms of the Medicaid provider agreement or failure to comply with the terms of provider certification on the Medicaid claim form.

G. Over-utilizing the Medicaid Program by including, furnishing, or otherwise causing a beneficiary to receive service(s) or merchandise not otherwise required by the beneficiary.

H. Rebating or accepting a fee or portion of a fee or charge for a beneficiary referral.

I. Submission of a false or fraudulent application for provider status.

J. Conviction against a provider for a criminal offense related to his or her involvement in the Medicaid or Medicare Program.

K. Failure to meet standards required by State or Federal law for Medicaid participation (i.e., failed to meet the licensing requirements constituting minimum qualification).

L. Exclusion from Medicare because of fraudulent or abusive practices (i.e., terminated or suspended from participation in the Medicare Program under 42 CFR, Part 1001.)

M. Failure to correct deficiencies in provider operations after receiving written notice of these deficiencies from the Single State Agency.

N. Failure to repay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments.

O. Termination for cause under Medicare or under the Medicaid or CHIP program of any other State [42 CFR § 455.416 and Section 6501 of the Affordable Care Act]

Key Federal & State Laws Protecting Medicaid Integrity

Medical Assistance Recipient Fraud S.C. Code 43-7-70

- Makes it illegal to knowingly provide false information or conceal material facts on applications for South Carolina Medicaid benefits, as well as for recipients to sell or transfer their benefits, classifying it as medical assistance recipient fraud, a Class A misdemeanor punishable by up to three years in prison or a $1,000 fine, or both.

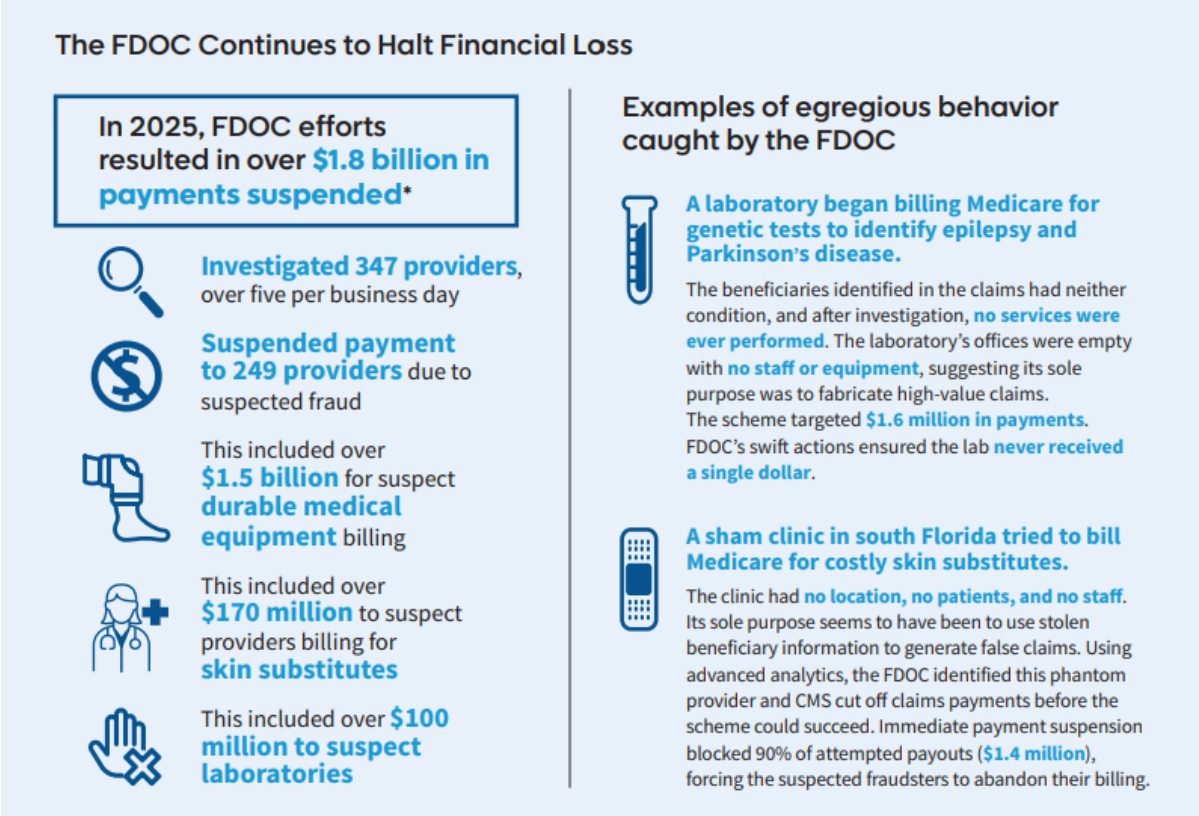
Key Federal & State Laws Protecting Medicaid Integrity

Besides the specific health care fraud statute included in this training, South Carolina has several other general criminal statutes which are often used in conjunction with a health care fraud prosecution, as follows:

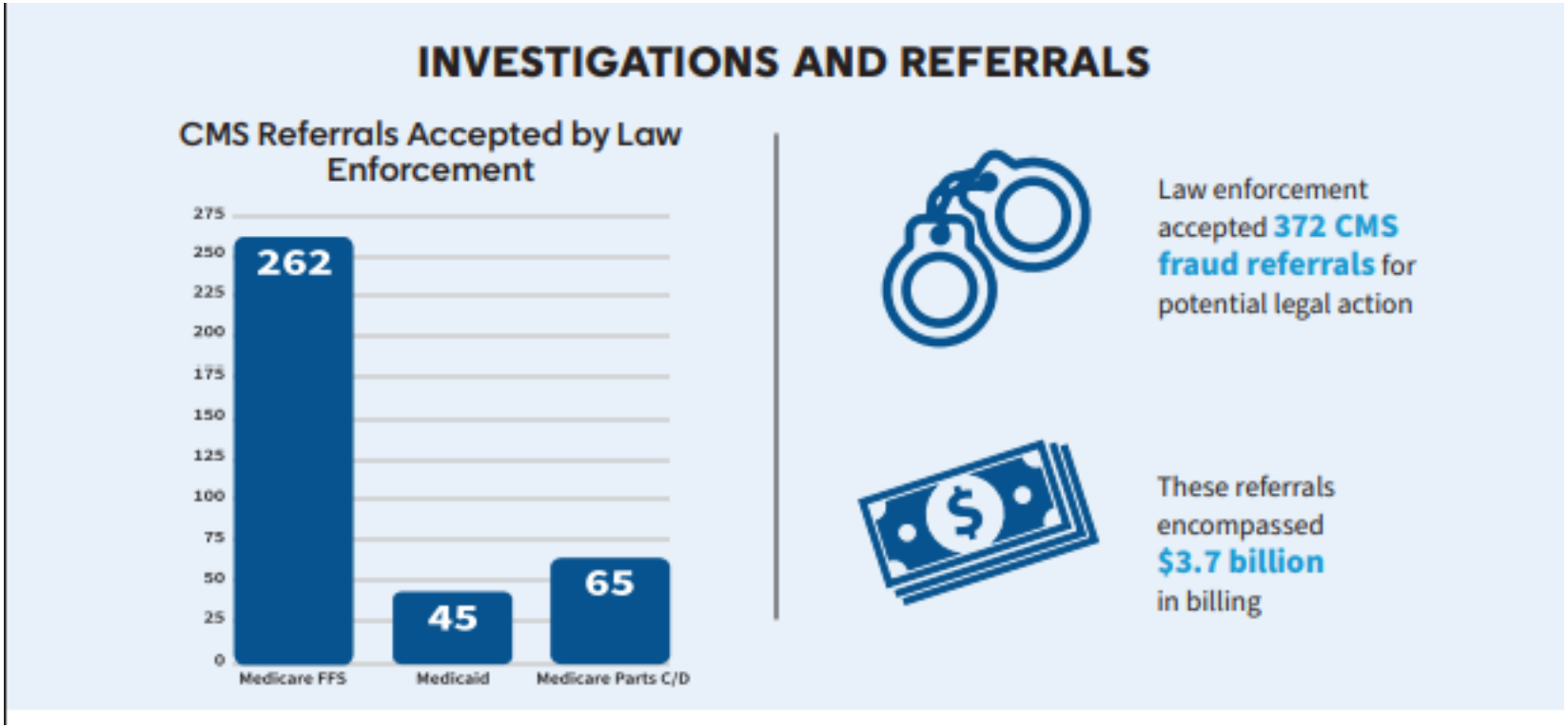
- S.C. Code 43-35-85 Patient Abuse and Neglect
- S.C. Code 38-55-540 Insurance Fraud
- S.C. Code 16-16-20 Computer Fraud
- S.C. Code 16-17-410 Conspiracy

CMS Fraud defense Operations Center

- Launched in March 2025. Integrates Cross-Functional Expertise through specialized team of data analysts, investigators, health policy experts, legal advisors, and law enforcement.



CMS Referrals Accepted by Law Enforcement



MOLINA HEALTHCARE

Recent Cases

Mt. Pleasant Man Sentenced to Nine Years in Federal Prison for Role in One of the Largest Medicare Fraud Schemes in History

- Andrew Chmiel, 48, of Mt. Pleasant, was sentenced to nine years in federal prison yesterday for his role in a nearly $100 million scheme related to the payment of kickbacks and bribes in exchange for medically unnecessary durable medical equipment (DME) orders.
- Chmiel's charges were brought in 2019 as part of Operation Brace Yourself, an investigation that originated in South Carolina. Operation Brace Yourself, which was prosecuted in conjunction with the Department of Justice's Criminal Division Fraud Section, was a multi-jurisdictional investigation that involved the execution of more than 80 search warrants in 17 federal districts.
- As for Chmiel's criminal conduct, evidence presented to the court showed that Chmiel controlled and operated at least 10 DME companies, which were located throughout the United States. These DME companies were used by Chmiel and his coconspirators to submit false and fraudulent claims to Medicare for braces that were not medically necessary and/or were obtained through the payment of kickbacks and bribes.
- To effectuate the scheme, these DME companies entered into agreements with an offshore call center to purchase completed doctors' orders so the DME companies could bill Medicare. This offshore call center was advertising through television and internet advertisements. Once a Medicare beneficiary called a 1-800 number that was on the advertisements, that Medicare beneficiary would be screened for eligibility and then convinced that he or she needed a brace, and oftentimes upsold on other braces. The call center would then contact a telemedicine company whose physician and/or or nurse practitioner would issue a prescription without regard to the medical necessity. Throughout the investigation the evidence revealed that beneficiaries were prescribed braces without ever being examined by, seeing, or, in some instances, even speaking to a medical professional. Evidence presented showed that Chmiel was attempting to hide that he was purchasing completed doctors' orders by creating fraudulent and false invoices for alleged marketing and business processing services.
- Throughout the health care fraud scheme, Chmiel's companies, which included 10 DME companies, two dropship companies, and two additional companies that were used to facilitate the fraud – D.O. Delivery and Pain Center – billed Medicare in excess of $200 million and Medicare paid Chmiel's companies in excess of $95 million.
- Chmiel was also held accountable at sentencing for an obstruction of justice enhancement pursuant to the United States Sentencing Commission Guidelines. Based on evidence presented by the Government during the sentencing, the court held that when Chmiel testified as a government witness in a trial in the Eastern District of New York against a coconspirator, he knowingly gave false testimony on matters material to the health care fraud scheme, violating the terms of his plea agreement.
- United States District Judge Joseph F. Anderson sentenced Chmiel to 108 months imprisonment, to be followed by a three-year term of court-ordered supervision. There is no parole in the federal system. The court also ordered that Chmiel pay $98,935,533.00 in restitution.

Recent Cases

Lancaster County Trio Pleads Guilty To Conspiracy To Commit Health Care Fraud

- Evidence obtained in the investigation revealed that Charles and Tika Griffin owned and operated a business called Transformation Services. Transformation Services purported to provide behavioral health services to Medicaid beneficiaries. Transformation Services worked together to recruit beneficiaries from disadvantaged backgrounds, sign the beneficiaries up as clients, and to then submit bills and records to the State of South Carolina for behavioral health services that were never rendered. The conspirators also provided services by unlicensed counselors in violation of the law. Through this scheme Transformation Services defrauded the state Medicaid program of at least $246, 335.12.
- The Transformation Services scheme came after Charles Griffin was barred from serving as a provider in the Medicaid program following an investigation into a similar potential scheme through a different entity. Following that action by the state, Transformation Services was established with Tika Griffin, Charles Griffin's spouse, as the president of Transformation Services, and with Charles Griffin given no formal role in the organizing documents.
- Each defendant faces a maximum penalty of 10 years in federal prison. They also face a fine of up to $250,000, restitution, and three years of supervision to follow the term of imprisonment. United States District Judge Mary G. Lewis accepted the guilty pleas and will sentence each defendant after receiving and reviewing a sentencing report prepared by the U.S. Probation Office.

Recent Cases

Two Upstate Medicaid providers charged with fraud

- South Carolina Attorney General Alan Wilson announced that his office's Vulnerable Adults and Medicaid Provider Fraud unit (VAMPF) has arrested Tami Ferguson Stewart, 65 years old, of Simpsonville, S.C., and Sydney R. Weiss, 27 years old, of Pickens, S.C., for alleged Medicaid provider fraud.
- **Charges:**
- Both defendants face:
- One count each of Forgery, value $10,000 or more {§ 16-13-0010(A)}
- One count each of Criminal Conspiracy (§ 16-17-0410}
- One count each of Medical Assistance Provider Fraud {§ 43-07-0060}
- A VAMPF investigation revealed that, between September 27, 2023, and February 25, 2024, Tami Stewart and Sydney Weiss conspired to defraud the South Carolina Department of Health and Human Services (SCDHHS), the agency that administers South Carolina's Medicaid program.
- Investigators allege the following:
- Stewart, the owner of Above and Beyond Care Services, LLC, knowingly submitted fraudulent employee timesheets to SCDHHS for payment. These timesheets falsely claimed that personal care and respite services had been provided to a Medicaid beneficiary when, in fact, the services were not provided. The total amount of the fraudulent claims exceeded $10,000.
- Weiss, an employee of Above and Beyond Care Services, LLC, knowingly and willfully signed and submitted false timesheets representing that she had personally provided personal care and respite services to the same Medicaid beneficiary when she had not rendered those services. As a result, Weiss caused fraudulent claims totaling more than $10,000 to be submitted to Medicaid.
- Is being prosecuted by the Attorney General's Office.

Recent Cases

Border Wars

- In 2025, South Carolina and North Carolina partnered with the FBI, OIG and IRS to investigate Medicaid fraud schemes that stole more than $21 million from South Carolina taxpayers. This case was part of the Justice Department's national healthcare fraud takedown that resulted in 324 defendants being charged in connection with more than $14.6 billion in alleged fraud.
- Federal criminal charges were filed in the Western District of North Carolina against eight individuals who allegedly conspired to defraud the South Carolina Medicaid Program (SC Medicaid) of more than $21 million by filing false and fraudulent reimbursement claims for behavioral health care services that were either inflated or not provided at all. It is alleged that these individuals bought and sold personal identifying information (PII) of SC Medicaid beneficiaries, and submitted reimbursement claims for patients who never knew their information was being used and never received the services. To carry out the scheme, the co-conspirators allegedly filed thousands of fraudulent claims using a network of companies in the Charlotte area and elsewhere. SC Medicaid beneficiaries are permitted to receive behavioral health services from qualified North Carolina providers located within a 25-mile radius of the South Carolina borders.
- Seven individuals were charged with conspiracy to commit health care fraud and to pay and receive illegal kickbacks.
- This case is being prosecuted.

Molina SC Compliance Expectations

- **Training & Awareness**
- Provide ongoing training to all staff, contractors, and providers on:
  - Fraud, Waste, and Abuse (FWA) prevention
  - Ethical decision-making in healthcare
  - Applicable federal and South Carolina state laws
- **Policy Development & Enforcement**
  - Maintain clear, written policies for **prevention**, **detection**, and **correction** of compliance issues.
  - Ensure policies are accessible, understood, and consistently applied.
- **Collaboration & Accountability**
  - Cooperate fully with internal and external **audits**, **reviews**, and **investigations**.
  - Respond promptly to compliance inquiries from Molina or state regulators.
- **Ethics & Integrity**
  - Avoid actual or perceived **conflicts of interest** in all business dealings.
  - Promote a culture where integrity, transparency, and accountability are expected at every level.

Provider Responsibilities

- **Verify Member Eligibility Before Services**
  - Confirm Medicaid and Molina SC coverage **before each visit** using approved verification systems.
  - Identify service limits or prior authorization requirements to avoid billing errors.
- **Bill Only for Medically Necessary, Documented Services**
  - Submit claims only for services that are **clinically appropriate** and **fully supported** by documentation.
  - Avoid upcoding, unbundling, or billing for services not rendered.
- **Maintain Accurate & Complete Records**
  - Keep clear, legible, and detailed patient records in compliance with state and federal retention requirements.
  - Ensure documentation supports **diagnoses, treatment plans, and billed services**.
- **Ensure Subcontractors & Partners Meet Compliance Standards**
  - Confirm that all business associates, contractors, and partners comply with **Molina SC, Medicaid, and federal requirements**.
  - Maintain written agreements outlining compliance obligations.

Reporting fraud, waste and abuse

- Molina Alertline is a telephone and web-based reporting is available 24 hours a day, 7 days a week, 365 days a year. When a report is made, callers can choose to remain confidential or anonymous.
  - Phone: (866) 606-3889
  - Website: MolinaHealthCare.Alertline.com
- Fraud, waste or abuse cases may also be reported to Molina's Compliance department anonymously without fear of retaliation at:

Molina Healthcare of South Carolina, Inc.
Attn: Compliance
PO Box 40309 North Charleston, SC 29423-0309

Remember to include the following information when reporting:

✓Nature of complaint

✓The names of individuals and/or entity involved in suspected fraud and/or abuse including address, phone number, Molina Member ID number and any other identifying information.

- Suspected fraud and abuse may also be reported directly to the State at:

SC Department of Health and Human Services Medicaid Fraud and Abuse Hotline
Phone: (888) 364-3224
By Email: fraudres@scdhhs.gov

South Carolina Attorney General Vulnerable Adults and Medicaid Provider Fraud Unit
By Phone: (803) 734-3660 or (888) 662-4328
By Email: VAMPF@scag.gov
Or mail complaint to: South Carolina Attorney General's Office Vulnerable Adults and Medicaid Provider Fraud Post Office Box 11549
Columbia, SC 29211-1549

MOLINA HEALTHCARE

Non-Retaliation Policy

- **Our Commitment**
  - Molina strictly prohibits retaliation against anyone who makes a **good-faith report** of suspected fraud, waste, abuse, or any other compliance concern.
- **What is Retaliation?**
  - Any adverse action taken against a person for reporting a concern or participating in an investigation.
  - Examples include:
    - Termination, demotion, or suspension
    - Reduction in hours or pay
    - Harassment, intimidation, or threats
    - Negative changes to work assignments
- **Legal Protections**
  - Federal and South Carolina laws protect whistleblowers from retaliation.
  - Protections apply whether the concern is substantiated or not — as long as the report was made in **good faith**.
- **How We Support You**
  - Reports can be made **confidentially** through Molina's Compliance Hotline or designated reporting channels.
  - Molina will promptly investigate all concerns and take corrective action if retaliation occurs.

Key Takeaways

- Understand FWA definitions and examples
- Know your legal and contractual obligations
- Report concerns promptly through proper channels
- Maintain a culture of compliance and ethics