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TESTIMONY

OF

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ATTORNEY GENERAL OF NORTH CAROLINA

BEFORE

NORTH CAROLINA HOUSE SELECT COMMITTEE ON OVERSIGHT AND REFORM

Investigation and Prosecution of Medicaid Provider Fraud

APRIL 16, 2026

Honorable Co-Chairs and Members of the Committee,

I am Jeff Jackson, the Attorney General of North Carolina.

Thank you for the opportunity to appear before you today to discuss the North Carolina Department of Justice's Medicaid Investigations Division (MID) and its work to investigate and prosecute Medicaid provider fraud and patient abuse.

INTRODUCTION

We are completely aligned on this: There is no acceptable level of fraud in North Carolina. We must fight it aggressively, everywhere.

At NCDOJ, we are our state's Medicaid-provider investigators and prosecutors. We take that work very seriously, and our results back that up.

The Medicaid Investigations Division (MID) exists to ensure that every single taxpayer dollar in the Medicaid program goes towards funding real patient care.

When we suspect or are referred potential fraud by Medicaid providers, we investigate those cases carefully and thoroughly. Based on the hard evidence, we prosecute the fraudsters and pursue both active jail time and repayment of Medicaid dollars. Our team is led by experienced criminal prosecutors and civil enforcers, who do this work hand-in-hand with local, state, and federal law enforcement and prosecutors.

The Medicaid Investigations Division is North Carolina's Medicaid Fraud Control Unit. Every state and territory that administers Medicaid is required by federal law to have this unit, and the units are overseen by the U.S. Department of Health and Human Services' Office of Inspector General (HHS-OIG). MID's compliance and effectiveness is reviewed and certified by HHS-OIG on an annual basis.

North Carolina's MID is one of the most efficient and productive Medicaid Fraud Control Units in the nation. Between 2019 and 2025, MID recovered \$296,014,563, the eighth highest recovery total in the nation. For every dollar of federal funding we received in that time, we recovered about \$6.28 for Medicaid – the fourth highest recovery rate in the nation. In its history, MID has recovered a total of \$1,222,243,867.21 in restitution and civil damages. (See Appendix A.)

MID's staff are nationally-recognized leaders in the National Association of Medicaid Fraud Control Units (MFCU) and help coordinate and lead multistate efforts to combat Medicaid fraud investigations with their partners in Republican and Democratic AG offices throughout the country. North Carolina's Medicaid fraud prosecutions are some

of the best examples of law enforcement working together to bring offenders to justice and win back what rightfully belongs to the people of North Carolina.

ABOUT THE MEDICAID INVESTIGATIONS DIVISION

Under federal law, the MFCU must be separate and distinct from the Medicaid agency to maintain independence and objectiveness in prosecutorial decision-making. MFCUs are responsible for investigating and prosecuting healthcare provider fraud, physical abuse of patients, and the stealing or improper commingling of patients' funds in Medicaid-funded facilities. MFCUs also investigate and prosecute fraud relating to the diversion or misuse of pharmaceuticals when the conduct involves a potentially fraudulent claim submitted to Medicaid or another federal health program.

When we convict a healthcare provider who has defrauded Medicaid or abused a patient, HHS removes that provider from being able to participate in federally-funded healthcare programs, including Medicare and Medicaid. That means that if you commit fraud one time and we convict you, you're out of the business. The restitution in our criminal cases goes back to the Medicaid program. When we recover double or triple damages under the False Claims Act in civil cases, the restitution portion goes back to the Medicaid program, and the penalty portion of these settlements goes to the North Carolina Civil Penalty and Forfeiture Fund to support public schools.

Under federal law, **MID cannot use federal grant funds to investigate and prosecute Medicaid recipients for recipient or beneficiary eligibility fraud.** The county Departments of Social Services and the North Carolina Department of Health and Human Services are responsible for investigating beneficiary eligibility fraud, and those cases are prosecuted by local district attorneys.

MID is led by Director and Senior Deputy Attorney General Eddie Kirby, who is here with me today. The Division currently has a total of 67 employees, which includes criminal prosecutors, civil attorneys, financial investigators, and nurse investigators who work on cases.

MID is jointly funded by the state and the federal government. The Division receives 75 percent of its annual funding through a federal grant from HHS-OIG. The Division receives the remaining 25 percent of its annual funding from the North Carolina General Assembly, which means that we return more money into the system than we spend in state dollars. Recently, the General Assembly provided funding for 15 new positions over the past two fiscal years, which has been incredibly helpful in our ability to investigate and prosecute fraudsters.

MID PARTNERSHIPS

MID works closely with our law enforcement partners and other agencies, especially the United States Attorneys' Offices in the Western, Middle, and Eastern Districts of North Carolina. MID attorneys prosecute cases in both state and federal courts. They are appointed as Special Assistant U.S. Attorneys (SAUSAs) in all three federal districts, and they serve as special prosecutors in North Carolina district attorneys' offices.

The Division also investigates and prosecutes cases with other state and federal agencies, including the Federal Bureau of Investigation, HHS-OIG, the Internal Revenue Service, the Department of Defense – Defense Criminal Investigative Service, the Drug Enforcement Administration, the United States Postal Service, the North Carolina Department of Health and Human Services, the North Carolina Department of Insurance, the State Bureau of Investigation, local law enforcement, and other states' Medicaid Fraud Control Units.

HOW MID INVESTIGATES AND PROSECUTES CASES

Referred Investigations

MID receives referrals for investigation from local law enforcement agencies, NCDHHS' Office of Compliance and Program Integrity, managed care organizations (MCOs), whistleblowers who witness employers and colleagues possibly breaking the law, and members of the general public who suspect illegal activity. We investigate every referral we receive and prosecute cases when we determine there is sufficient evidence to prove fraud. (See Appendix B.)

When the state Medicaid agency, administered by NCDHHS, receives a complaint of Medicaid fraud or abuse or identifies any questionable practices, it conducts a preliminary investigation. If NCDHHS has reason to believe that a provider has committed fraud or abuse, it refers the matter to MID for further investigation.

Proactive Investigations: Data Mining

MID does not exclusively rely on referrals from other sources in order to combat Medicaid fraud. Since 2017, MID has been taking proactive measures to investigate potential fraud through data mining Medicaid claims data. North Carolina's MID was one of the first states in the nation to obtain permission from HHS-OIG to begin this work, and we started identifying potential subjects for investigation and enforcement action. To date, MID's data mining efforts have yielded 68 investigations into a variety of provider

types, including dentists, pediatricians, laboratories, internal medicine physicians, and non-residential mental health facilities. We have had the following prosecutorial results:

- 6 criminal convictions with a total of \$27,185,469.07 in ordered restitution
- 18 civil False Claims Act settlements totaling \$10,891,473.82 in ordered restitution and penalties

MID is actively engaged in data mining in a range of areas, including Applied Behavior Analysis therapy, urine drug testing, and skin substitutes. NCDHHS provides MID with access to NCTracks (the Medicaid Management Information System for North Carolina) and supports MID staff's data mining efforts. We coordinate our data analytics work with partners, including HHS-OIG, sister MFCUs, and NCDHHS. These partnerships are partly why data mining is so successful – when information isn't shared, and different groups of investigators are investigating potential fraud separately, it's harder to identify patterns and shut down fraud.

MID does not currently have any positions dedicated solely to data mining. All efforts are taken on by existing staff in addition to their regular duties. With additional resources in this area, our MID could be even more effective at rooting out fraud.

TYPES OF MEDICAID FRAUD

Services Not Provided

Fraudulent billing makes up a majority of recent MID convictions. In particular, MID prosecutes Medicaid providers who bill Medicaid for services or medical supplies that weren't actually provided to patients. This drives up Medicaid costs for taxpayers, and results in patients not getting the care they actually need. In the last fiscal year, more than 80 percent of the convictions we obtained were related to fraudulent billing.

In January, we secured [a prison sentence](#) for a licensed clinical mental health counselor who submitted claims for more than 900 services to Medicaid patients that he did not actually provide. The Medicaid program ended up paying out more than \$70,000 as a result of those claims. That referral came from an MCO that detected suspicious activity and reported it to the N.C. Division of Health Benefits (DHB) Office of Compliance and Program Integrity (OCPI), which then sent it to our office.

We worked closely with the N.C. Department of Insurance and the Wake County District Attorney's Office on this case, and the defendant has been ordered to repay the Medicaid program.

Billing Fraud

We also prosecute cases where providers use the wrong billing code to get a higher reimbursement, submit separate reimbursements for the different parts of a procedure instead of submitting the procedure as a less-expensive bundled code, provide services that the patients don't medically need to get more Medicaid dollars, or enlist patients in their scheme to bill for services not provided and pay kickbacks to the patients.

In March, we sentenced the final of five defendants in [a \\$12.7 million Medicaid fraud scheme](#). In that case, the defendants were paying kickbacks to patients to get them to show up for expensive lab tests and services that the defendants then billed to Medicaid. The defendants, who operated Life Touch and 1st Choice Healthcare, are repaying more than \$12.7 million to Medicaid and IRS. We prosecuted this case in partnership with EDNC U.S. Attorney Ellis Boyle's office. **This investigation and prosecution came specifically from our office's data mining efforts.**

Patient Abuse

MID also investigates and prosecutes resident abuse cases in healthcare facilities that receive Medicaid funding. These cases almost always involve "at-risk" adults who cannot care for themselves. It is essential to hold those who harm some of our most vulnerable citizens accountable.

With respect to patient abuse matters, MID works with the N.C. Division of Health Service Regulation, which licenses and oversees adult care facilities. We also receive and make referrals to the licensing boards for healthcare professionals.

Last year, a healthcare technician at a Kinston developmental center pleaded guilty to repeatedly striking and injuring a developmentally disabled resident. This conviction was obtained in partnership with the Lenoir County District Attorney's Office and the NCDHHS Police Department.

Civil Claims and Whistleblower Reporting

MID also uses its civil authority under the False Claims Acts (FCA) to hold people accountable who knowingly submit false claims to the government. A person found liable for violations of the FCA must pay triple damages for each false claim submitted.

In addition, whistleblowers can file FCA cases on behalf of the government. In January, we reached a settlement with Bethany Medical Center to repay nearly \$9 million for allegedly billing federal healthcare programs for drug tests that patients didn't actually

need. That case was brought by a former employee who filed a whistleblower claim. Importantly, whistleblower claims are required by law to be kept under seal as our office investigates.

PROGRAM RECOMMENDATIONS

In the course of investigating and prosecuting cases, we sometimes identify areas in which programmatic improvements can be made that would prevent or combat future fraud. In the past year, MID has made program recommendations to NCDHHS with respect to the following issues:

- With the sharp increase in Medicaid claims for treatment of Autism Spectrum Disorder (ASD), MID recommended providing clearer definitions in the DHB Clinical Coverage Policy with respect to Research-Based Behavioral Treatment (RB-BHT). This would provide clarity on what services should or should not be covered by Medicaid and would strengthen future prosecutions for fraudulent billing.
- MID recommended that DHB include language in its provider agreements with respect to providers' requirement to produce records to MID upon request. This would make the provider agreement language consistent with federal law, and it would help our investigations move more quickly.
- MID recommended that providers of urine drug testing be required to include the ordering provider's National Provider Identifier (NPI) in claims for urine drug testing – otherwise, the claim should not be processed and paid. This would enable our investigators to conduct better data analytics to root out suspicious billing.
- MID recommended the development of a requirement and reporting mechanism for an added level of inquiry on the provider enrollment application as to the level of Clinical Laboratory Improvement Amendments (CLIA) certification the provider has requested and/or obtained as part of the application process. MID also recommended that an edit be introduced into the Medicaid Management Information System (MMIS) that distinguishes those providers who are allowed to perform only presumptive testing. This would make clear who can bill for certain lab services and who cannot.

CONCLUSION

We are grateful for the General Assembly's support of MID's healthcare fraud enforcement efforts.

Thank you again for giving me the opportunity to testify today, and I'm happy to answer your questions or provide additional information now and later.

APPENDIX A: CASELOAD, CONVICTIONS, CIVIL FCA RECOVERIES

This chart provides an overview of MID's results over the past three full Federal Fiscal Years (FFY), and for FFY 2026 at the mid-point.

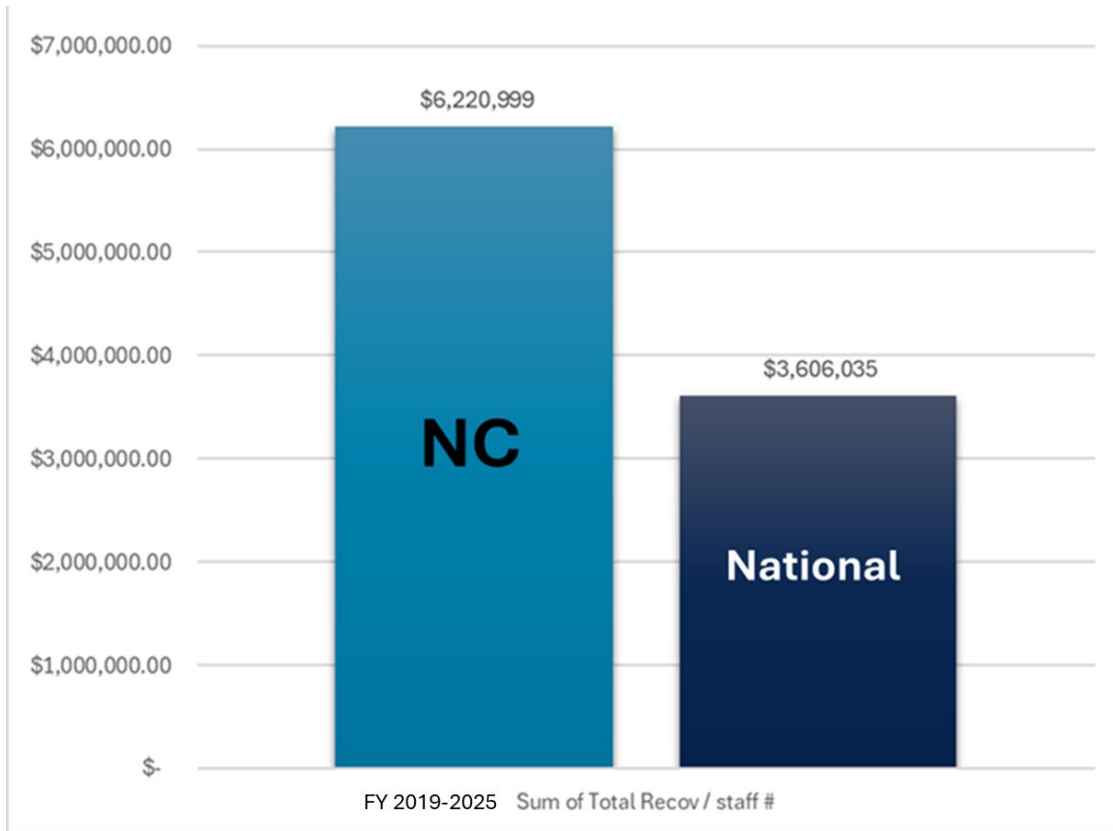
FFY	Criminal Convictions	Restitution	Civil Settlements	Civil Recoveries	Total
2023	8	\$31,548,009.65	14	\$12,078,369.02	\$43,626,378.67
2024	5	\$10,031,949.94	13	\$10,990,003.16	\$21,021,953.10
2025	7	\$8,398,952.81	11	\$8,243,446.41	\$16,642,399.22
2026 (to date)	9	\$68,876,115.52	9	\$12,011,743.43	\$80,887,858.95

Since its creation in 1979, MID has won 697 criminal convictions and 556 civil recoveries. In its history, MID has recovered a total of \$1,222,243,867.21 in restitution and civil damages. This represents a return on investment of **\$8.25** for every dollar invested in our Unit.

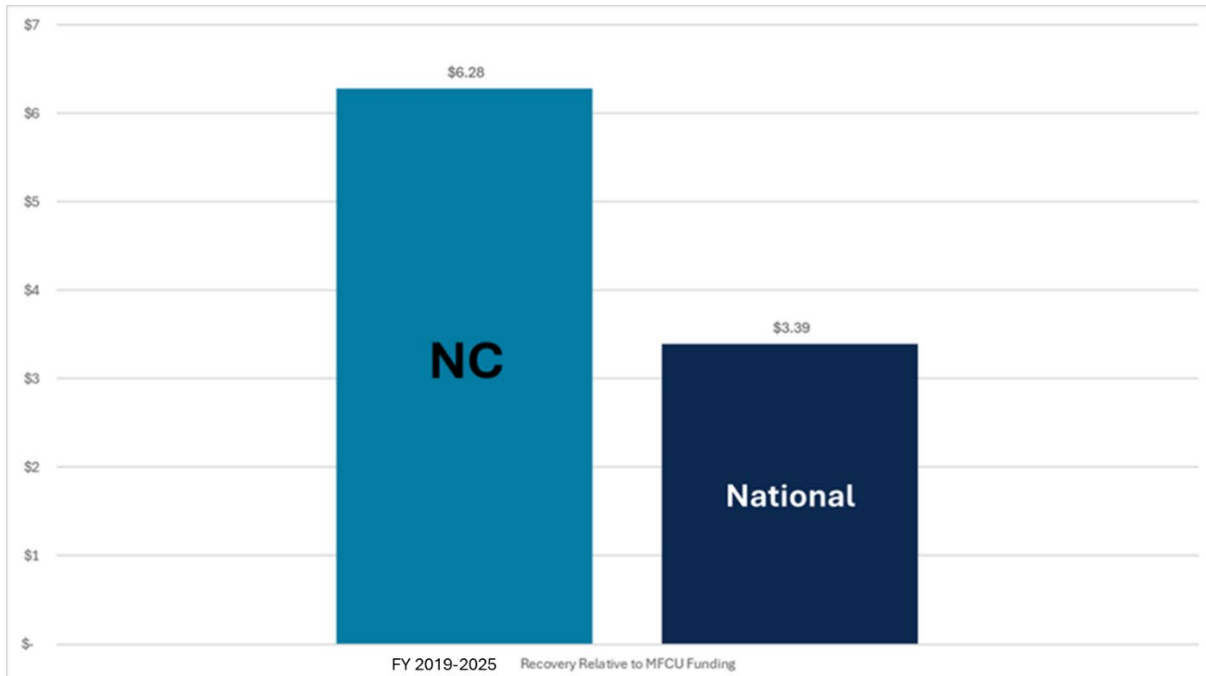
However, this return on investment does not tell the whole story. A 2024 paper from the [Healthcare Fraud Prevention Partnership](#) explained that the deterrent effect in healthcare fraud cases may be \$10 for every dollar recovered by the government.

As of April 2026, MID currently has 95 active criminal cases and 290 civil cases.

MFCU Recoveries relative to staffing: MID vs. the national average



MFCU Recoveries relative to funding: MID vs. the national average



APPENDIX B: REFERRALS

The NCDHHS Office of Compliance and Program Integrity (OCPI) is an important source of referrals. The chart below shows MID's referral numbers from OCPI in recent years. Some of these referrals were based on OCPI's own efforts to identify, preliminarily investigate, and report credible allegations of fraud to MID. Others are fraud referrals that originated with the Medicaid managed care plans and were sent to OCPI for further development before being submitted to MID.

Federal Fiscal Year	OCPI Referrals to MID	Originating from MCOs	Not Originating from MCOs
2023	122	87	35
2024	130	123	7
2025	42	20	22
2026 (to date)	113	103	10

In addition to referrals from OCPI and managed care plans, MID also actively seeks Medicaid fraud referrals directly from the general public. MID's phone number is printed on the back of Medicaid ID cards, and beneficiaries are asked to call it to report fraud. NCDOJ's website also actively seeks citizen referrals to MID, either through MID's phone number (919-881-2320) or through a dedicated online fraud reporting portal: <https://ncdoj.gov/medicaid-provider-fraud-complaint-form/>.

NC DOJ's website also encourages the public to report beneficiary fraud (such as fraudulent eligibility or transfer of assets) to the North Carolina Division of Health Benefits at 1-800-662-7030 or through an online portal to NC Medicaid Office of Compliance and Program Integrity (OCPI).