

STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

JOSH STEIN
GOVERNOR

DEVDUTTA SANGVAI
SECRETARY

WRITTEN TESTIMONY OF SECRETARY SANGVAI
North Carolina Department of Health and Human Services
Before the House Select Committee on Oversight and Reform

April 16, 2026

Chair and Members of the Committee:

Thank you for the opportunity to appear before you today to discuss the integrity of North Carolina's Medicaid program. Oversight is not only appropriate – it is essential. While we remain confident that our oversight and performance are robust, we also acknowledge that any amount of fraud is too much. I appreciate the Committee's focus on oversight and accountability and welcome the chance to outline how the Department protects public funds while serving the people of North Carolina.

Program integrity is central to the mission of the North Carolina Department of Health and Human Services. NC Medicaid is one of the largest public investments we make, and with that investment comes a clear obligation to be responsible stewards of taxpayer dollars. Medicaid serves more than three million North Carolinians, including children, seniors, individuals with disabilities, and working families. Protecting the integrity of the program is not separate from serving these individuals, it is vital to it. Every safeguard we put in place ensures resources are going toward quality health care for the people who depend on it.

NC Medicaid's approach to program integrity is comprehensive, structured, and grounded in both legal requirements and best practices. Federal and state laws require that any allegation of fraud, waste, or abuse be reviewed and investigated, and NC Medicaid complies fully with that mandate. Every complaint is subject to a preliminary review to determine whether further investigation is warranted, and credible allegations are pursued through appropriate channels, including referral to law enforcement when necessary.

The scale of oversight reflects both the size of the program and the strength of the systems in place. In calendar year 2025, there were 114,454 enrolled providers and 228 credible allegations of provider fraud were reported and investigated. Additionally, there were 3.1 million members enrolled and 158 credible allegations of member fraud were reported and investigated. As of February 25, 2026, 64 credible allegations have already been reported this year. Currently, 22 providers are under review for credible allegations, and 91 providers have been referred to the Medicaid Investigations Division within the Department of Justice and are under active investigation. These figures represent a significant increase compared to prior years, when the average number of providers referred for investigation was substantially lower. This increase is not indicative of a weakening system, but rather enhanced oversight and improved analytics have strengthened our ability to identify and act on potential fraud.

NC Medicaid employs multiple layers of protection to prevent, detect, and address fraud, waste, and abuse. We have federal oversight, state audits, internal audits, county reviews, managed care plans, and law enforcement all working together to ensure accountability at every level. In 2025 alone, NC Medicaid underwent three federal audits, four state audits, and three internal audits. In other years, this figure is even higher. Our Medicaid Managed Care Plan partners are on the frontlines of this work – and are required to develop a Fraud Prevention Plan, establish a Special Investigations Unit, and report allegations of fraud, waste, or abuse to the Department. Our managed care partners cooperate with Medicaid Investigations Division or the Department’s direction regarding the investigation, work to mitigate potential financial or other harm, and recover overpayments. The Department has invested in advanced data analytics that continuously monitor claims and identify unusual patterns or outliers which may indicate improper billing. NC Medicaid, in close partnership with local Department of Social Services offices, verifies beneficiary eligibility through extensive electronic data sources, from Social Security to state systems like the Department of Motor Vehicles and the Department of Corrections. These systems allow NC Medicaid to proactively detect potential issues rather than relying solely on external reports. Together, these efforts create a network of oversight that expands the State’s capacity to detect and respond to issues.

According to a federal Payment Error Rate Measurement audit, North Carolina’s eligibility systems maintain an error rate of approximately 0.46 percent, one of the lowest in the nation. At the same time, strong front-end safeguards ensure that providers are appropriately screened before enrollment and continuously monitored thereafter, including background checks, site visits for higher-risk providers, and ongoing credentialing.

In addition to prevention and detection, NC Medicaid maintains robust audit and enforcement processes. Post-payment reviews identify improper billing or insufficient documentation, and when inappropriate payments are identified, the Department pursues recoupment to recover those funds. These efforts, along with prepayment review which catches issues before a payment is made, generate tens of millions of dollars annually in recoveries and cost avoidance. Utilization controls, including prior authorization requirements and service limits, further ensure that services provided are medically necessary and consistent with program rules. Eligibility safeguards are also critical. NC Medicaid uses enhanced connections to federal data systems to verify eligibility, conduct regular redeterminations, and cross-check records to prevent improper payments, including those associated with deceased individuals.

Where matters fall outside the Department’s direct authority, such as certain insurance broker activities, they are referred to the appropriate regulatory entities to ensure accountability. When fraud or noncompliance is confirmed, providers may be removed from the program and referred for enforcement actions, including prosecution and financial recovery.

NC Medicaid also continuously evaluates areas of higher risk within the program and adjusts oversight accordingly. This includes monitoring high-cost services and emerging trends in pharmaceutical utilization to ensure appropriate use and cost management. These efforts are part of a broader commitment to ensuring that resources are used efficiently and in alignment with clinical standards.

Looking ahead, NC Medicaid is expanding program integrity tools and partnerships. Advanced analytics and artificial intelligence are being deployed to detect emerging fraud schemes, summarize patterns from recent cases nationwide, and generate targeted queries. Staff are reviewing system edits and audits to identify additional opportunities to flag questionable claims before they are paid. Key audit functions, including recipient eligibility reviews, are being automated to reduce manual work, improve accuracy, and accelerate detection. Coordination with oversight partners is being strengthened through updating our memoranda of understanding with the Medicaid Investigations Division to better align referrals and investigations, along with timely communication with the Office of the State Auditor to ensure responsiveness to audits.


It is important to have strong safeguards in place to prevent fraud, waste, and abuse, both to protect taxpayer dollars and maintain trust in the program. But the reality is that this is not where most Medicaid spending goes - NC Medicaid has a strong track record of fiscal discipline, with about 98 percent of funds going directly to medical costs. The bigger issue is the rising cost of health care overall. Costs are going up due to more people using services, higher prices, and more complex care needs, including behavioral health and prescription drugs.

To keep the program affordable, the focus has to be on making sure care is appropriate effective, and evidenced-based, while also investing in keeping people healthy in the first place so they need less costly care over time. That means strengthening primary care, reducing the use of low-value services, supporting prevention, using lower-cost, equally effective treatments and settings when possible, and expanding payment models that reward outcomes and better coordination of care.

NC Medicaid screens providers before they enter the program, monitors activity while they participate, detects improper conduct, investigates, and enforces corrective action when needed. Protecting the program is essential to preserving it, and continued investment in technology, analytics, and collaboration will further strengthen these efforts. We share the Committee's commitment to accountability and stand ready to continue working together to ensure that NC Medicaid remains both effective and responsible. Our delivery model must focus on getting the beneficiary to the right care, in the right amount, at the right time, in the ideal setting.

Thank you for your time and consideration. I look forward to answering your questions.

Respectfully submitted,

Signed by:

FBA64E76EDDE414...

Devdutta Sangvai, MD, JD, MBA
Secretary