

JOINT LEGISLATIVE OVERSIGHT COMMITTEE
ON MEDICAID

NC Department of Health and Human Services

Medicaid Program Integrity

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NC Medicaid Program Integrity

NC Medicaid provides health coverage to more than 3 million North Carolinians

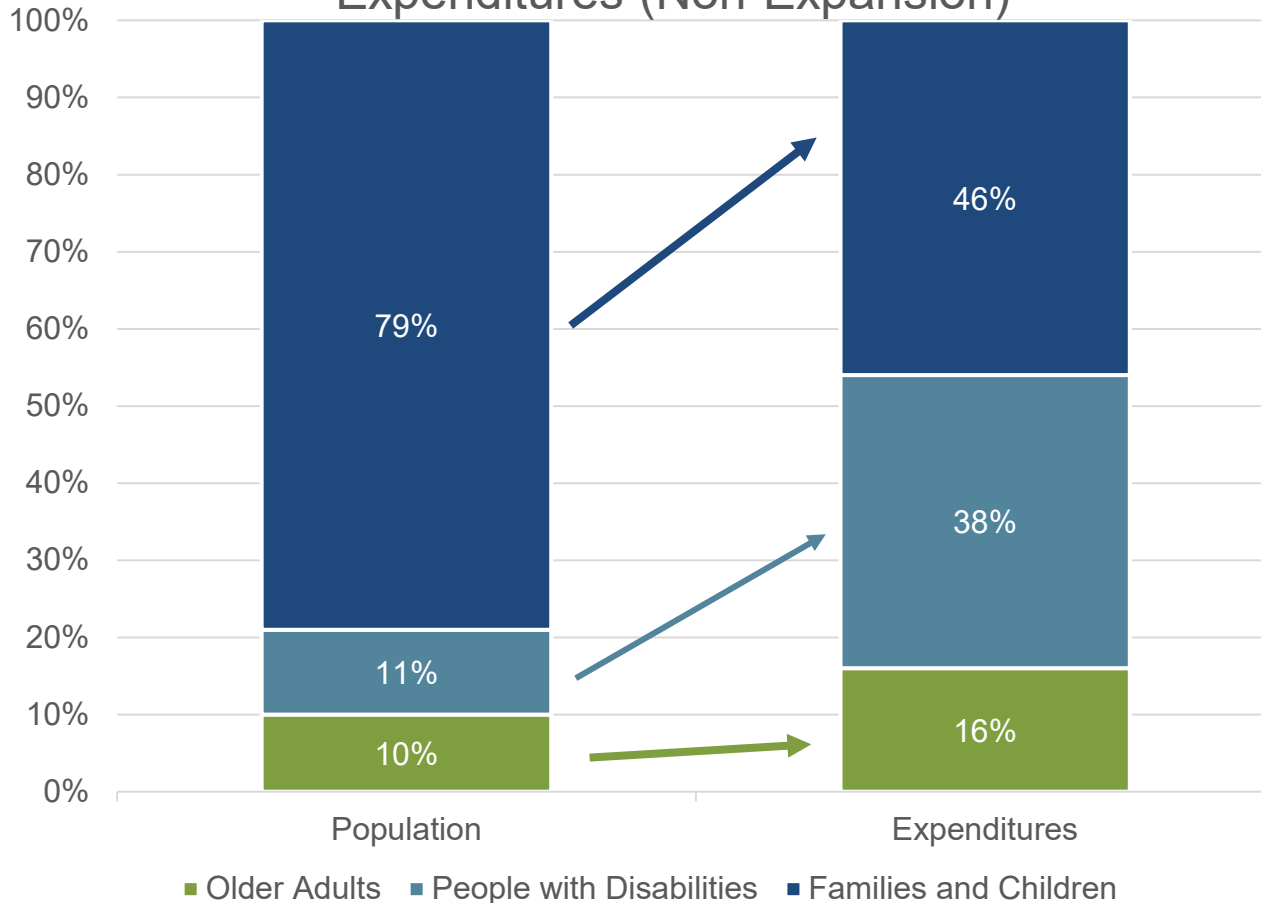
- Children, pregnant women, seniors, people with disabilities, and working families
- Supports rural hospitals, nursing homes, and essential care services
- Strong fiscal stewardship means 98% of expenditures go directly to care

Program Integrity Matters

- Protects taxpayer dollars
- Ensures appropriate, quality care
- Maintains public trust in the program

Reminder from March: Enrollment vs. Expenditure Drivers

Distribution of Medicaid Enrollment and Expenditures (Non-Expansion)



Families and Children represent 79% of enrollment but 46% of total expenditures. This remains the lower cost per capita segment of the program.

Older adults and people with disabilities account for 21% of enrollment but drive 54% of Medicaid spending.

Defining Fraud, Waste, and Abuse

Fraud	Waste	Abuse
<p>Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in unauthorized benefit to himself or some other person.</p> <p>Fraud is confirmed only by a court decision following a criminal investigation.</p> <p>N.C.G.S. §§ 108A-63, 64 also further define recipient and provider fraud, sets requirements around investigating fraud, and sets associated criminal penalties</p>	<p>While not defined in federal rules, generally understood to encompass the overutilization or inappropriate utilization of services and misuse of resources.</p>	<p>Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.</p> <p>10A NCAC 22F .0301 provides specific actions or inactions by providers that constitute abuse.</p> <p>Also includes beneficiary practices that result in unnecessary cost to the Medicaid program</p>

State and Federal Oversight

<p>US DHHS Office of the Inspector General (OIG) <i>(Federal)</i></p>	<p>Oversees (in relevance to federal regulations and requirements) state Medicaid FWA efforts by auditing, evaluating, and investigating whether states properly detect, prevent, and report fraud, waste, and abuse. OIG also ensures states return overpayments, follow federal requirements, and maintain effective program integrity controls.</p>
<p>CMS <i>(Federal)</i></p>	<p>Provides federal oversight of state Medicaid program integrity by setting requirements, conducting reviews and audits, and monitoring whether states effectively prevent, detect, and address fraud, waste, and abuse.</p>
<p>North Carolina Office of the State Auditor (OSA) <i>(State)</i></p>	<p>Provides independent oversight of the Medicaid program by conducting financial, compliance, and performance audits to verify that state agencies and counties administer Medicaid accurately and in accordance with state and federal requirements. OSA's findings help identify weaknesses in internal controls or procedures to help assure regulations are met and reduce FWA.</p>
<p>NC DHHS Office of the Internal Auditor (OIA) <i>(State)</i></p>	<p>Conducts the annual EAGLE Audit to evaluate internal controls, compliance with policies, and the effectiveness of program integrity safeguards. OIA identifies vulnerabilities, recommends corrective actions, and supports continuous improvement across NCDHHS to ensure Medicaid funds are protected and managed responsibly.</p>
<p>NC Medicaid Office of Compliance and Program Integrity <i>(State)</i></p>	<p>Provides structured oversight of provider program integrity by maintaining centralized compliance policies, monitoring adherence through case tracking and analytics, and coordinating timely corrective actions across health plans, vendors, and internal units. It also strengthens statewide FWA controls by facilitating training, issuing compliance guidance, and reports that ensure consistent enforcement of Medicaid requirements.</p>
<p>Managed Care Organizations (MCO) <i>(State)</i></p>	<p>Serve as a frontline oversight entity by conducting provider monitoring, detecting and investigating potential fraud, waste and abuse, and ensuring providers comply with all Medicaid requirements. MCOs are also required to promptly report suspected provider fraud to the State and take corrective or administrative action when issues are identified, strengthening overall program integrity.</p>

Multilayered Oversight Framework

Oversight Entities



Recurring Audits



Beneficiary Program Integrity Efforts

NC is a State-supervised, county-administered eligibility system. Counties determine eligibility and conduct beneficiary-fraud investigations. State sets policy, provides tools, oversees compliance, and audits county performance

Eligibility and Enrollment Support for Applications and Recertifications

Applications

- Multiple submission pathways:
 - Applicant self-service – online FFM, ePASS, or mail
 - Applicant supported – caseworker entry with applicant in office or on the phone
- NC is a federally facilitated marketplace determination (FFM-D) state. If someone applies for health coverage at the FFM and are determined eligible for Medicaid, applications are sent to counties with an eligibility determination made
- Monthly Report Cards track county application processing timeliness to ensure federal compliance

Recertifications

- Recertifications must be completed annually. Counties begin the process 90 days prior to end of certification period
- Caseworkers attempt to complete all recertifications without contacting the beneficiary when electronic data confirms eligibility
- Federal law requires that beneficiaries do not lose Medicaid coverage without a completed recertification. Cases are extended until a recertification is complete

NCGS § 108A-25.1A. Responsibility for errors: County DSSs are financially responsible for Medicaid claims payments for an ineligible individual

Electronic Verification Sources Used For Medicaid Eligibility

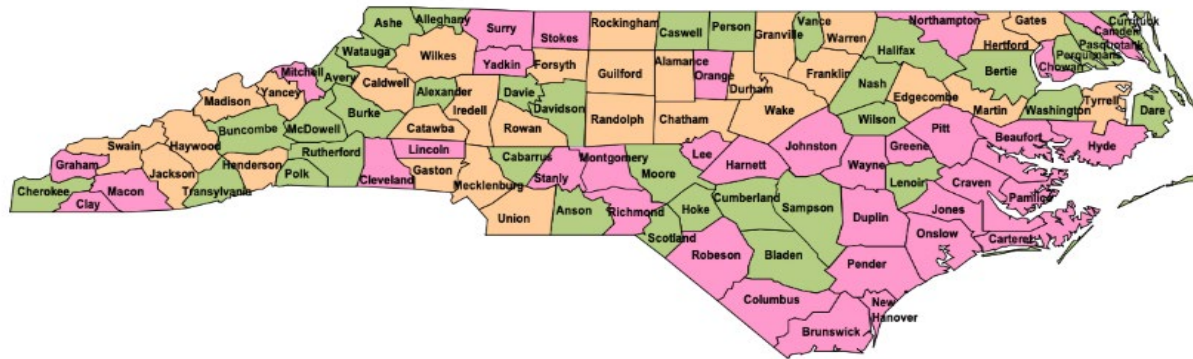
The following CMS-approved verification sources are used in the NC FAST eligibility system to verify attested information (e.g., citizenship, social security number, income)



Beneficiary Eligibility Audits

Audit engagements that include a review of county eligibility determinations to confirm member eligibility was properly determined:

- **Recipient Eligibility Determination Audit** – Performed by NC Medicaid Compliance over a 3-year cycle



- **State Single Audit** – Performed annually by the NC Office of the State Auditor
- **County Single Audit** - Performed annually by each county’s local CPA firm
- **Payment Error Rate Measurement** – Performed every 3 years by the Centers for Medicare and Medicaid Services
- **Medicaid Eligibility Quality Control** – Performed every 3 years by NC Medicaid Compliance as directed by CMS

NC's Beneficiary Eligibility Audit Results (State & Federal)

REDA Audit Results – State

Eligibility Accuracy Categories	Acceptable Accuracy Thresholds per County	Cycle I Statewide Averages (CY 2019-2021)	Cycle II Statewide Averages (CY 2022-2024)
Approvals	96.8%	96.0%	95.7%
Denials/Terminations	96.8%	94.0%	93.0%

Overpayments Summary – State

REDA Overpayment Metric	Cycle I CYs 2019-2021	Cycle II CYs 2022-2024
Counties w/ overpayments	75	65
Total Overpayment Amount <i>(recouped per NCGS § 108A-25.1A)</i>	\$101,183.30	\$208,511.92

2023 PERM Eligibility Error Rate – Federal

	North Carolina Est. Rate	2023 Cycle 2 States Est. Average	2023 National Est. Average
Est. federal improper payment rate due to Eligibility errors	0.46%	3.90%	5.95%

National Benchmarking citation OIG. (2023). 2023 Medicaid & CHIP Supplemental Improper Payment Data. <https://www.cms.gov/files/document/2023-medicaid-chip-supplemental-improper-payment-data.pdf>

NC Beneficiary Eligibility Audit Results

REDA Accuracy Improvement Plan (AIP)			
Cycle/Year	# Counties per Cycle/Year	# Counties Met	# Counties Did Not Meet
I	100	26	74
2019	30	9	21
2020	35	9	26
2021	35	8	27
II	100	81	19
2022	30	21	9
2023	35	29	6
2024	35	31	4

Eligibility Accuracy Categories	Acceptable Accuracy Thresholds per County
Approvals	96.8%
Denials/Terminations	96.8%

Provider Program Integrity Efforts

NC Medicaid's Office of Compliance and Program Integrity (OCPI) coordinates efforts for fraud, waste, and abuse statewide through central intake, triage, and credibility review system for all suspected fraud allegations

42 CFR Part 455, Subpart A and 42 CFR § 438.608

NC Medicaid compliance responsibilities, include but are not limited to:

- Maintain policy governance and administer provider compliance standards
- Conduct triage, case tracking, and analytics to identify high-risk provider behavior
- Vet referrals submitted by MCOs, contractors, and internal sources to determine whether allegations are credible.
- Refer credible criminal allegations to the Medicaid Investigations Division (MID) at the NC Department of Justice and support active MID cases through data analysis and investigative coordination.
- Carry out administrative actions (education, corrective action, overpayment, policy guidance) when matters do not yet reach the criminal threshold
- Provide statewide training to MCOs to improve referral quality.

Ensuring Accurate Provider Enrollment

- Providers apply to enroll in NC Medicaid through an electronic **NCTracks application**
- Once approved, providers may participate in both Medicaid Managed Care and Medicaid Direct (Fee for Service)
- State law (NCGS 108C-2.1(b)) requires providers to revalidate their enrollment **every 5 years**
- In 2025, NC Medicaid's provider data management platform earned **NCQA accreditation** after new safeguards were added, including:
 - Collecting and reviewing **more detailed information** during enrollment and revalidation (malpractice history, education/work history, board certification)
 - Creating a **multi-payer Credentialing Committee** to review provider files with flagged issues and make enrollment or revalidation decisions

Electronic Verification Sources Used for Medicaid Provider Enrollment

All providers are subject to background checks through the NCTracks at application and reverification. Credentialing information must be primary source-verified; providers cannot supply information directly to NC Medicaid.

Enrollment Application (completed by provider)

- Provider Name/National Provider Identifier (NPI)
- Provider taxonomy
- Exclusion Questions – convictions, prior disciplinary actions, license restrictions, drug use, or program exclusions
- Completion of NC Medicaid New Provider Training

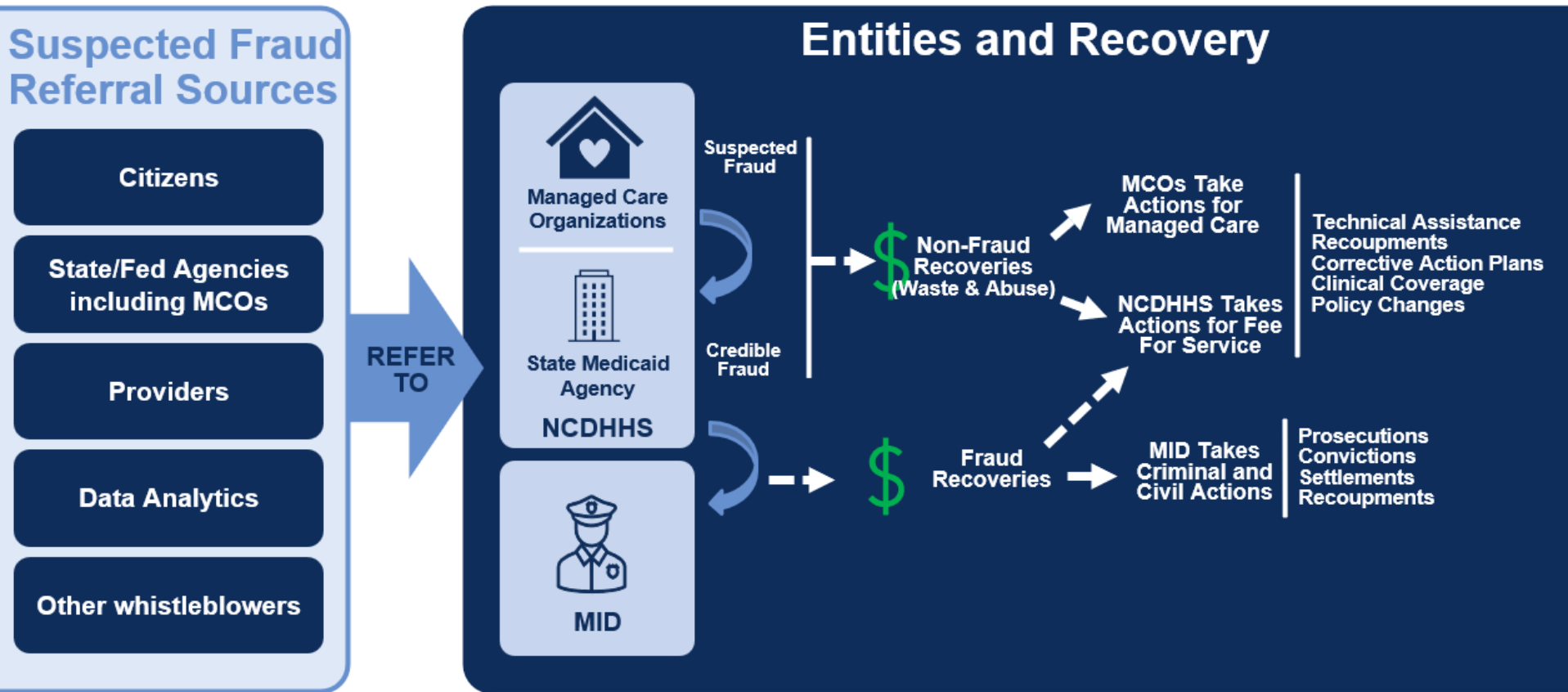
Credentialing (completed via NCTracks through primary source documentation and verification)

- Fingerprinting for high-risk provider types (defined in [NCGS §108C-3](#))
- Site visits for moderate and high-risk provider types (as defined in [NCGS §108C-3](#))
- Criminal Background checks*

* All providers, owners with 5% or more direct or indirect ownership, and managing employees

- State licensure boards
- NC Medicaid required certifications
- NC Medicaid required accreditations
- NCDHHS Provider Penalty Tracking Database
- CMS (CLIA certification, Medicaid and Medicare Revocations/ Terminations)
- Drug Enforcement Administration (Prescribing authority)
- Lexis Nexis (DBA, OIG/LEIE, SAM/EPLS, Criminal history, SSN, Date of Death)

Program Integrity Intake and Referral



Program Integrity in Managed Care

Managed Care Organizations must meet more than 150 requirements across programs focused on compliance, program integrity, and fraud prevention.

MCOs Program Integrity Responsibilities per Contract

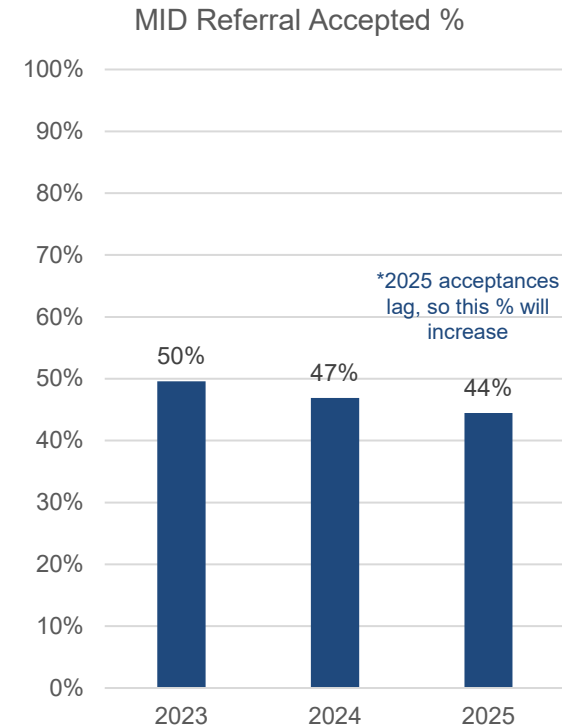
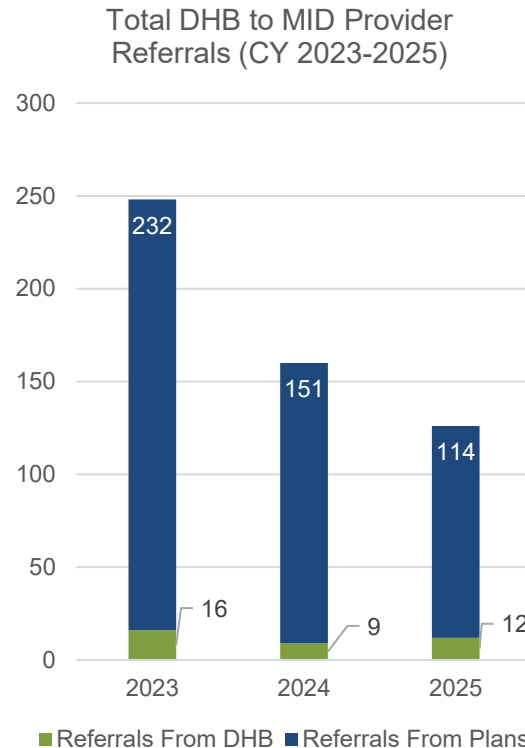
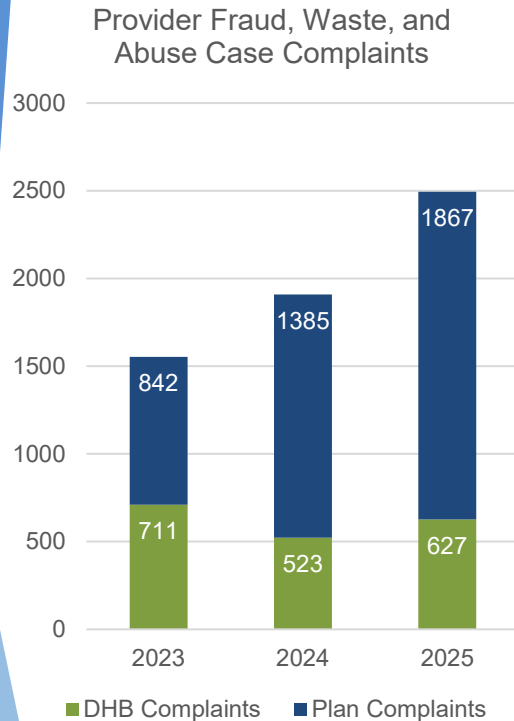
- Maintain internal checks (pre-pay and post-pay) to find, investigate, and report possible fraud, waste, and abuse
- Send fraud referrals to DHB with all required documents, data, and findings
- Work with State on investigations, payment suspensions, and data requests
- Report and promptly recover any overpayments
- Join State oversight meetings, trainings, and corrective actions
- Provide regular reports to the state on FWA-related terminations, complaints, overpayments, and similar issues

Available Tools for MCOs Program Integrity Efforts

- Perform internal reviews of providers, including investigations and audits
- Take administrative actions like education, corrective action plans, or prepayment review
- Use data analysis to spot unusual billing or quality of care concerns
- Hold or deny claims when documentation is missing or policies aren't followed
- Remove providers from the network for quality, compliance, or contract issues
- Coordinate with internal teams such as Special Investigations Units, clinical reviewers, vendors, and legal counsel

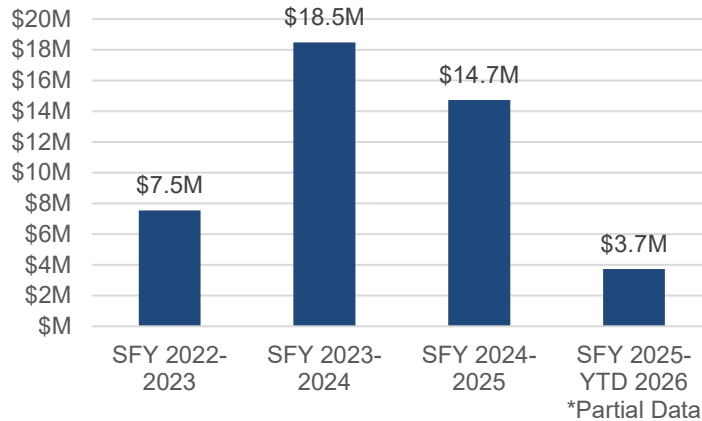
Program Integrity Provider Fraud Referrals

Summary of Complaints to DHB | Overall: DHB Referrals to MID & Acceptance % (CY 2023 - CY 2025)

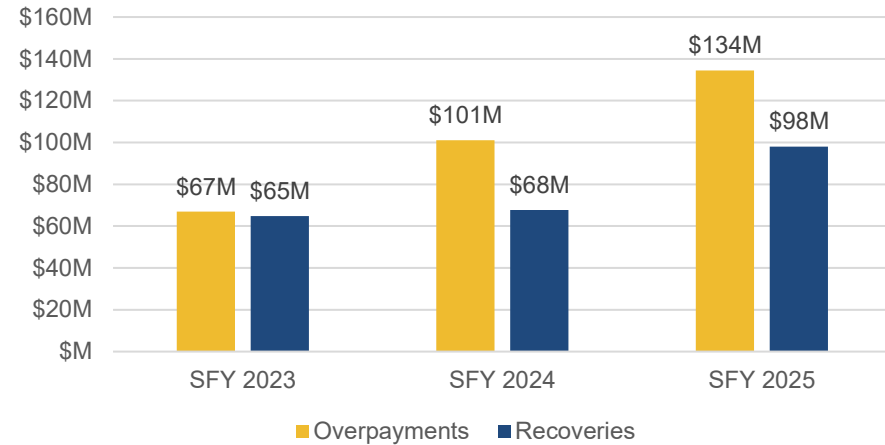


Program Integrity Outcomes

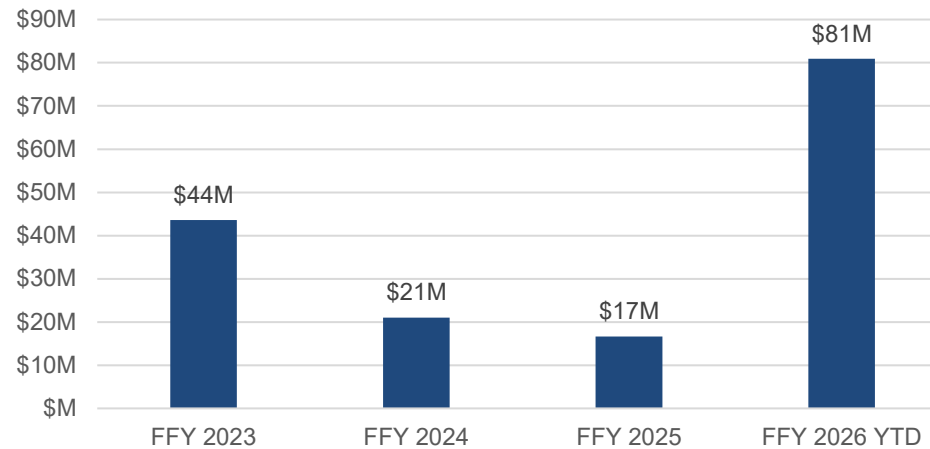
Cost Avoidance Achieved Through Prepayment Review in Fee For Service (Waste/Abuse)



MCO and OCPI Overpayments and Recoveries



MID Fraud Convictions and Settlements (FFY 2023 – 2026 YTD)



Note: All figures represent total State/Federal share dollars

Additional Program-Wide Program Integrity Support

Education

- Provided education to long term care providers on using Electronic Visit Verification (EVV) system to ensure services were really provided, helping prevent fraud and wasted taxpayer dollars
- Built a tool to help the State see which providers need more training on using EVV correctly

Exclusions

- 19 providers were removed from the Medicaid program this year because they did not meet requirements

MID Case Data Analytics Support

- Completed 3 Provider Analysis Packages to support 40 MID provider investigations and provided additional advanced data analytics support to MID

Current NC Program Integrity Focus Areas

DHB conducts annual risk assessments to determine current year priority and data mining plans.

Annual Risk Assessment of services uses current DHB inputs:

- Beneficiary count
- Dollar value of claims paid by service
- Review frequency
- Trends identified by MCOs
- External oversight entities risk assessments (i.e. CMS, OIG, OIA, NC OSA)

Current Areas of Focus:

- Durable Medical Equipment (DME)
- Personal Care Services
- Behavioral Health (ABA, Peer Support)
- Non-Emergency Medical Transportation (NEMT)

Looking Ahead

Detection Improvements

- DHB is using new AI tools to strengthen detection of fraud, waste, and abuse.
 - AI tools pull recent cases from across the country, summarize common schemes, and suggest data queries.

System Enhancements

- We are initiating a review of system edits and audits to identify additional pre-adjudication opportunities to catch questionable claims before they are paid.
- Automating the Recipient Eligibility Determination Audit (REDA) using AI to reduce manual work, improve accuracy and help DHB spot errors more quickly.

Interagency Collaboration

- Update Memorandum of Understanding (MOU) with the NC Department of Justice Medicaid Investigations Division to enhance workflow and increase information sharing timeliness.
- Continue in responsive engagement with OSA audits, and explore partnership to better coordinate referrals and investigations around waste and abuse, specifically
- Continue work with federal partners at CMS on new tools and opportunities to coordinate across states