

Rep. Campbell, Chair: [00:00:15](#)

I'd like to welcome everyone to today's hearing on Oversight and Reform, and I'd like to thank you all for being here. First, I'd like to recognize our sergeants-at-arms for their service and professionalism. Today we have Michael Galloway. We have David Leighton and Stafford Young. We appreciate you guys being here.

[00:00:58](#)

Regardless of policy or position, everyone in this room can agree that rising healthcare costs continue to put significant pressures on citizens providing for their own families and taxpayers across the state. North Carolina's Medicaid program exceeds \$36 billion annually. That is more than the state's entire General Fund. While the federal government covers roughly two-thirds, the state's required share last year was more than \$6 billion. That is taxpayer money, and it requires a commitment to vigilant oversight.

[00:01:38](#)

Since 2019, Medicaid enrollment has expanded dramatically, from 1.9 to nearly 2.9 million participants: an increase of 984,000 people, which exceeded the entire population growth of our state during the same period. This is the highest percentage enrollment increase of any state in the nation. During this period, several other states enacted Medicaid expansion, and every state experienced COVID, yet we outpaced them all. This rapid increase is aggravated by DHHS policies that provide little to no oversight for confirmation of eligibility or meeting requirements for re-enrollment.

[00:02:25](#)

Disenrollment can occur when proper procedures are not followed or recipients are found to be ineligible. And common theme, North Carolina is essentially dead last in this category. For renewal of Medicaid coverage, this can be done *ex parte*, which is essentially automatic renewal or submission of forms and verification information. The percentage of re-enrollments in North Carolina that required submission of information and verification of income was less than one percent, which is dead last in the United States.

[00:02:58](#)

This lopsided focus on enrollment with little to no effort in verifying continued eligibility leaves me with only two possible explanations. Either we are committed to maintaining the highest enrollment possible, regardless of eligibility, to maintain numbers for future budgets, or we simply are not looking. Either of these tactics are not only unsustainable, they are unacceptable.

- [00:03:25](#) Meanwhile, administrative costs have increased. Somehow, Medicaid spends twice as much on administration with managed care organizations than it did when it paid providers directly for services, which is baffling, since one of the main pitches in managed care organizations was decreasing administrative costs.
- [00:03:45](#) North Carolina's Medicaid Fraud Control Unit, the Medicaid Investigation Division of the Department of Justice, is tasked with detecting and prosecuting provider fraud and patient abuse. Yet federal reporting shows that recoveries have stagnated even as caseloads are rising. North Carolina has the eighth largest Medicaid program in the country by cost, but ranks 29th among all states on recoveries per Medicaid dollar and 47th on convictions for Medicaid fraud control unit staff.
- [00:04:19](#) While private managed care organizations analyze data to spot problem providers, both DHHS and DOJ depend more on whistleblower tips than their own data analytics. In testimony to the Medicaid Joint Legislative Oversight Committee, Secretary Sangvai showed waste, fraud, and abuse complaints from the managed care organizations grew from 842 to 1,897 between 2023 and 2025, while complaints from the agency fell, the number of referrals (regardless of source) fell, and the rate at which these referrals turned into cases also fell.
- [00:05:03](#) DOJ reportedly dedicated just 131 staff hours to data analysis. This is not sustainable. We must ask how many millions are being lost to waste, fraud or abuse before a single case is opened? How many investigations result in convictions, settlements, or recoveries, and how long does it take to intervene once red flags appear? One area that illustrates this problem is autism therapy. Applied Behavioral Analysis therapy is essential for children with autism, but a sharp rise in new autism diagnoses led this body to raise reimbursement rates 15%, and that combination has driven provider claims up astronomically and drawn private equity firms into the market.
- [00:05:58](#) Medicaid spending on ABA was \$122 million in 2022, \$640 million last year, and is projected to be \$1.1 billion next year. Worried parents and free flowing money create opportunity for bad actors, providers billing for services not rendered or delivering care of questionable quality. While legitimate patients wait months for an appointment, leading up to the politically motivated cuts to those providing healthcare to the people of our state in October of 2025 by Governor Stein,

Representative Reeder and I asked, "What were the factors contributing to the alarming increase in ABA cost?"

[00:06:46](#) We were told the department did not have time to look into it. During that time, however, there was plenty of time for DHHS officials, including the Secretary and then Medicaid Director Jay Ludlam, to engage in a PR campaign to twist public opinion to force the General Assembly to continue the endless flow of taxpayer dollars to Medicaid without allowing questions to be asked about the potential of waste and fraud occurring.

[00:07:15](#) Private insurance plans typically spend twice as much as Medicaid on administrative oversight, but that extra cost goes to fraud detection and audit infrastructure. Medicaid by contrast remains largely reactive, recovering only a fraction of improper payments. We can and we must do better.

[00:07:35](#) Our goal is simple: a well-defined, well-managed Medicaid program that serves those who truly need care and spends wisely enough to be sustainable. There is a difference between meeting the true needs of our citizens and enabling irresponsible and lax behavior by a bureaucracy. Rooting out waste, fraud, and abuse isn't just a fiscal issue, it is a moral one. Every dollar misused is a dollar not spent on a child with autism, a senior needing care, or a patient waiting for treatment.

[00:08:11](#) I would ask that everyone testifying today follow a ground rule if you can. One of the reasons we are here today is that outreach from General Assembly members to DHHS requesting information and sharing concerns about waste, inefficiency, or potential fraud is often replied with vague and delayed responses promoting the goals of programs without giving specific answers to concerns voiced about how the program is being executed. If a program is run inefficiently or wastefully, the goals of the program are not being met. So, I ask each of you today to give direct answers to direct questions.

[00:08:52](#) We're joined today by Department of Health and Human Services Secretary Dev Sangvai and Attorney General Jeff Jackson, who will help us understand what the state is doing and what more we can do to strengthen accountability and oversight. If you would both please stand and raise your hands, and also anyone you will defer to for answers, please stand to be sworn in as well.

[00:09:18](#) Do you affirm that your testimony is the truth, the whole truth, and nothing but the truth?

Jackson and Sangvai: [00:09:23](#) Yes.

Rep. Campbell, Chair: [00:09:23](#) Thank you. You may be seated. Members, as usual, each of you will have five minutes for questions. You may use your full time without seeking permission for follow-ups. After everyone has finished their first round, we will return for additional questions as time allows. Please signal when you'd like to be recognized. For starters, I'm going to recognize Representative Chesser.

Rep. Chesser: [00:09:53](#) Thank you, Mr. Chair. Secretary Sangvai, AG Jackson, welcome to House Oversight. I'm sure you guys had a circle around this on your calendar all week.

[00:10:05](#) I'm just going to jump right into it. Secretary Sangvai, we've already talked about how this program is massive, \$35 million, or excuse me, billion, covering about three million people in our state. A program that size, do you believe that you oversee—do you believe there are any meaningful inefficiencies within that program?

Mr. Sangvai: [00:10:28](#) Good morning committee and thank you, Chairman Campbell, and thank you, Representative Chesser, for that question. We are a big agency, as you outlined. A \$35 billion agency. When fully staffed, we will have 18,000 individuals as part of it. We cover everything from the Chief Medical Examiner to Vital Records, the Medicaid program, food and nutrition as well as the programs for licensing facilities and a few other services.

[00:10:57](#) There are inefficiencies. As we're talking specifically around Medicaid, one of the things that I committed to about a year ago, maybe in this exact room during my confirmation, was to identify those opportunities for inefficiency. One of the inefficiencies we have is; since we have transformed Medicaid, we have somewhere in the neighborhood of nine to twelve different Medicaid plans in North Carolina. And some of those plans subcontract with others to deliver these services.

[00:11:27](#) And so, what that creates is a complexity from which there are some benefits, particularly around maybe the fraud, waste, and abuse framework, but also a tremendous amount of work on our Division of Health Benefits to work with multiple plans under the various rules, being able to understand what one plan

is doing versus the other and creating some consistency around there.

[00:11:48](#)

It costs us millions of dollars a year to administer a plan. So, I can list other inefficiencies, but as we're specifically thinking about the Medicaid program, one of the opportunities is to think about what is the right number of plans. In order to move to that right number of plans, we'll need General Assembly action in order to think about how we may go from the number of plans we have to what would be the right size.

Rep. Chesser:

[00:12:10](#)

Okay. Let's talk about something you don't need General Assembly action to incorporate. When we look at your department, according to your annual report in 2025, DHHS received approximately 1,537 intake submissions complaints of suspected fraud. Of those, 895 were converted to fraud, waste, and abuse investigations. Of those roughly 900, do you know how many were actually referred to the Attorney General's office for criminal investigation?

Mr. Sangvai:

[00:12:41](#)

During that time period, about half of those would have been referred to the AG's office.

Rep. Chesser:

[00:12:45](#)

About half of those?

Mr. Sangvai:

[00:12:46](#)

Yes.

Rep. Chesser:

[00:12:47](#)

Our records reflect that it's 69 cases.

Mr. Sangvai:

[00:12:54](#)

I'll have to confirm that number, sir. Are you asking about 2025?

Rep. Chesser:

[00:13:08](#)

Yeah.

Mr. Sangvai:

[00:13:08](#)

2025, we referred 126 cases to the AG's office.

Rep. Chesser:

[00:13:17](#)

For enforcement?

Mr. Sangvai:

[00:13:18](#)

For review. Right.

Rep. Chesser:

[00:13:20](#)

How many resulted in enforcement?

Mr. Sangvai:

[00:13:21](#)

I'm not sure how many resulted in enforcement, but about half of those were then taken up by MID for investigation.

- Rep. Chesser: [00:13:30](#) So, what creates that drop? When you're investigating fraud, is it the position of your department that more of those cases or more of those reports are fraudulent themselves than the fraud and abuse that is actually occurring?
- Mr. Sangvai: [00:13:43](#) So, if it helps, let me give a framework on the manner in which the fraud, waste, and abuse complaints come to us. There are a number of pathways in which we receive a fraud, waste, and abuse complaint. The primary pathway is through those managed care organizations that I just outlined earlier. They're the sentries of our gate.
- [00:14:02](#) Contractually, they're required to identify fraud, waste, and abuse in the members who are part of their program. We also have the ability to receive complaints through the general public. We also have the ability to receive complaints as we identify through the Division of Health Benefits and through our own hotline.
- [00:14:20](#) That's the totality of claims that we come in. We can largely think about them in two buckets. The ones we directly get at DHB and those that are routed to us through the plans. So, in 2025, the totality of that was roughly 2,400 claims that came through both, directly to DHB as well as the plans.
- Rep. Chesser: [00:14:38](#) How many came just from the plans?
- Mr. Sangvai: [00:14:40](#) From the plans was 1,867 complaints of fraud, waste, and abuse in 2025.
- Rep. Chesser: [00:14:46](#) And how many of those were converted?
- Mr. Sangvai: [00:14:48](#) Of those, 114 were converted. And so-
- Rep. Chesser: [00:14:52](#) Why is it about 10% that are actually converted? You're ruling out 90% of claims, and then of those, we're making some recoveries.
- Mr. Sangvai: [00:15:00](#) Sure.
- Rep. Chesser: [00:15:01](#) So, how are we ruling it out when we know fraud and abuse exists?
- Mr. Sangvai: [00:15:04](#) Right, that's a really good question, sir. When you think about what constitutes a complaint, sometimes those complaints can include things like waste and abuse. So, if we think about fraud,

fraud is intentional action to deceive. When you think about waste, that's providing medical care that's perhaps not otherwise necessary. And then abuse is individuals who are taking advantage of the system.

[00:15:27](#)

So, a complaint could come in and say, "Hey, I saw my doctor yesterday, and my doctor, every time I go there, orders a complete blood count test on me. This doesn't make sense to me." So that would come to, let's say it comes through a health plan. We would look at that at DHB and say, "Hey, this is an education opportunity for the provider. This isn't a provider who's fraudulent. This is an opportunity for the provider to be educated."

[00:15:50](#)

So, we take the first cutoff of those that we suspect are not fraud because they represent opportunities to practice better. They represent opportunities to collaborate better and don't represent opportunities where necessarily you have someone who might be billing inappropriately or taking advantage of the system. So, that's why you see the drop off.

[00:16:08](#)

The filter we have is very big. We'd rather catch as many... Funnels a better description. We'd rather catch as many as we can. Some of the fraud, waste, and abuse complaints we get in are minor relative to what you might expect of someone who's upcoding when they're performing that complete blood test I'm talking about.

Rep. Chesser:

[00:16:25](#)

So, in that same time period, your department recovered about \$24 million. Is that accurate?

Mr. Sangvai:

[00:16:31](#)

During that time period, roughly through overpayments and recoveries, we recovered \$98 million in state fiscal year '25.

Rep. Chesser:

[00:16:45](#)

Well, we're going to have to rectify some numbers at the end of this so that we can be comparing apples to apples, but what percentage of the overall fraud do you think you guys actually collected on? I mean, that's a significant number in my book, but that's just what you're capturing. What percent of total fraud do you think you're actually capturing?

Mr. Sangvai:

[00:17:05](#)

Sure. So, if I go back to state fiscal year 2023, we had \$67 million of which we recovered \$65 million. In 2024, there was \$101 million of which we recovered \$68 million. And in 2025, \$134 million of which we recovered \$98 million. And so, you may be asking about the delta in the last two years. Some of

those are payments in arrears that we're expecting to get because some of these providers need to be put on payment plans in order to be able to get them. And then some of those are providers who we honestly cannot find.

Rep. Chesser: [00:17:39](#) Okay. So, to back up just for a brief second, Mr. Chair. If you've already stated that you need assistance from this body to continue discovering fraud and abuse, which tells me that you don't think you're capturing 100% of it. What percentage do you think you might be capturing in your opinion? How much more do you think could be out there?

Mr. Sangvai: [00:18:09](#) So, in order to anticipate how much fraud may be out there, we have to look at some benchmarks. So, nationally, there is a statistic that about 6% of Medicaid payments are considered to be inappropriate payments. When you look at that statistic, around 75% of those are largely due to insufficient data in the actual claim.

[00:18:34](#) So, if we were to look at 6% as being roughly the marker, and then you take off the 80%, which you can clarify through resubmission of claims and so forth, you're really luckily looking at around 2%, a fourth of that—roughly around 2%. So, you'd be looking at a good marker for North Carolina would be 2% could potentially be fraud. And so, when you look at the kind of numbers we have, we're roughly in that range.

Rep. Chesser: [00:19:01](#) Would you like to expand on providers you cannot find? How do we have people that we've paid money to that we cannot find?

Mr. Sangvai: [00:19:09](#) Yeah, these are the most nefarious of providers, sir. These are the individuals who find their way into the program, and then once they realize that they are not able to justify their actions—all the steps that we take to identify who those providers are—either they shut down shop, leave the state, or it's like any other criminal prosecution when you're trying to receive judgment from someone from whom judgment is required. We make every effort possible, including working with the Attorney General's office to identify these individuals, but some of them just quite frankly escape.

Rep. Campbell, Chair: [00:19:46](#) Thank you. The chair recognizes Representative Schietzelt.

Rep. Schietzelt: [00:19:51](#) Thank you, Mr. Chair. And thank both of you gentlemen for being here today. Obviously, we have some pointed questions

to ask today but appreciate your time and appreciate you being forthright.

[00:20:06](#)

I guess my questions are for Attorney General Jackson. Again, thank you, sir, for being here. I've been through your testimony, and I've been through a lot of the documents that you guys have provided the committee, and your testimony presents a strong picture of the Medicaid Investigations Division and some of the statistics that have come out of that. You're a good advocate. It's what an advocate does.

[00:20:32](#)

Unfortunately, some of the statistics that we have painted a little bit of a different picture. North Carolina ranks 37th among states right now in terms of total Medicaid fraud convictions. And I want you to check my numbers on this. If I don't have accurate numbers, I'd like to know.

[00:20:49](#)

The Department of Justice ranks ahead of only three states right now in terms of the number of convictions that it produces per employee, ahead of only New York, Montana, and Hawaii. And when the DOJ wins in its civil cases, collections have been less than 1%. Have I articulated anything here incorrectly? Let's start and make sure we level set.

Mr. Jackson:

[00:21:13](#)

I don't know if it's incorrect, but it is incomplete. So, with respect to our enforcement actions, it's important that everybody understands, we can go criminal and we can go civil. So, some of the numbers that you just cited were specifically about criminal but did not include civil, and that's about half of the enforcement actions that we take because proving fraud civilly is easier from an evidentiary standpoint than proving fraud criminally.

[00:21:44](#)

We take our cases criminal every single time the evidence supports it, but there are some cases where the evidence just doesn't support it because to take it criminal, you have to prove intent, and that is very difficult. There are also some cases that we can take civil and criminal, and we do that where we can. And there are some cases that start civil but end up criminal.

[00:22:07](#)

Like the Sims case you may have seen in the news last month, it was a fraudulent Medicaid provider. We punished them to the tune of several years in prison and \$12.7 million in cooperation with local US Attorney Ellis Boyle. We have great federal partners who we work with all the time. So, while I'm not sure any of those individual metrics are accurate or inaccurate, I do

believe they paint an incomplete picture with respect to our national comparison, because that's what those numbers purport to do is compare us to everybody.

[00:22:40](#)

All states have an MID—a Medicaid Investigations Division—and just to be clear, so we're all on the same page, we're 75% federal funded: Federal law says we can only go after Medicaid providers. We cannot go after Medicaid beneficiaries or recipients at NCDOJ. We are limited by federal law—because we are 75% federally funded—to focusing on Medicaid providers.

Rep. Schietzelt:

[00:23:08](#)

Mr. Attorney General, you've said a lot of things that I want to go ahead and touch on because there's a lot of follow-ups here. Again, we are talking about federal numbers. We're talking about all of the states operating under the same federal law, and we're talking about North Carolina's rankings with respect to these other states.

[00:23:25](#)

You also mentioned that the difference between civil and criminal, which is an important distinction, we did mention that the collections in these civil cases have been less than 1% of what has been recovered. So, the state hasn't actually recovered it. We have been entitled to recover it and entitled to collect it and have not collected on those according to the data that we have. Is that inaccurate?

Mr. Jackson:

[00:23:46](#)

I think that is inaccurate, and I would be interested in exactly what the source is for that. So, let me take both of the points you just made because the first one was comparing us to all 50 states nationally. This is the best way to determine our performance. There are going to be a lot of metrics that we talk about here, a lot that you can isolate. The most honest way to see how MID and North Carolina is doing is to compare us to our peers. I think that's the right instinct.

[00:24:12](#)

And when you do this, there is no question that North Carolina MID is punching way above its weight. We are nationally regarded as one of the finest and most effective Medicaid fraud investigation divisions in the country. Our leader, Eddie Kirby, who's here with me, who's done exclusively this work for 15 years, is probably the incoming president for the National Association of MIDs because he is regarded as a leader.

[00:24:41](#)

Here are the metrics to back this up. We are fourth in the nation for how much we recover per federal dollar of funding. We are eighth in the nation for total recovery over the last six years.

And to your last point about the difference between the amount of ordered recovery versus actual recovery—so, the court says, "Hey, you pay \$12 million to the state of North Carolina." And then how much do we actually recover? We usually actually recover less than the amount of money that's ordered because we send these people to prison.

Rep. Schietzelt: [00:25:18](#)

Mr. Attorney General-

Mr. Jackson: [00:25:19](#)

Which is where they belong.

Rep. Schietzelt: [00:25:21](#)

... that's actually not the thrust of my question, which is about civil actions that have been taken. So, if you talk about throwing someone in prison, earlier you went through this spiel, and a correct spiel, about the difference in standards between criminal prosecutions and civil actions—and so now it almost sounds like we're conflating the two.

[00:25:39](#)

I want to move on though because when you talk about criminal actions and the difficulty of bringing that, not having the evidence to prove that. What tools, what investigative tools does the Medicaid Investigations Division have in order to compile that evidence?

Mr. Jackson: [00:25:56](#)

That's a great question. Every single referral that we get—and we get a number of referrals from DHHS, but we've got six or seven different sources, major sources of leads that come in; over time, on average, roughly a sixth come from NCDHHS—every single referral that we get gets a trained investigator and a trained prosecutor specifically trained in Medicaid provider fraud.

[00:26:22](#)

The reason we can do that is because of the investment that this body has made recently in helping us to do that. So, the new people that you gave us let us make sure that every single referral gets a trained investigator and a trained prosecutor. In addition, we were the third state in the country to start data mining.

[00:26:45](#)

To your point, Representative Campbell, about the importance of focusing on data—this is going to be one of the big things that I want to talk to you about. We have been a national leader in this space. Other states are coming to us to learn about data mining, but this is still basically in its infancy. The investigators who we have doing this are doing this on top of their existing

full-time jobs, basically as a self-internally-funded pilot program. This has borne incredible fruit.

[00:27:11](#)

The case that I told you about from last month that resulted in five people going to prison and \$12.7 million ordered in restitution started as a data mining case. This is clearly the future. We're working with our federal partners on this. We have more access to data than any MCO, than any provider in the state. It makes sense that you would want to plus that up. We are asking you in this session for one full-time data-mining specialist. Best part is you only pay 25%. Federal government will pick up the other 75%. This is clearly the direction we need to go.

Rep. Schietzelt:

[00:27:52](#)

So, in terms of other tools, I mean, I'm familiar somewhat with DHHS and the post-payment claims review, prepayment claims review, the investigative tools that are available to DHHS. What about in terms of, again, criminal prosecutions, things like search warrants? Does MID have the ability to issue search warrants?

Mr. Jackson:

[00:28:09](#)

We can, but more effectively, we issue CIDs—civil investigatory demands. Anybody who is a Medicaid provider in this state, when they sign that contract with the state, part of that contract says if someone like me asks for documents, they have to send it over.

Rep. Schietzelt:

[00:28:24](#)

Can those leads... And again, the word civil is in there. Can those assist with criminal prosecutions?

Mr. Jackson:

[00:28:30](#)

Yes.

Rep. Schietzelt:

[00:28:30](#)

Okay. So, again, I've read through your testimony, and I just want you to kind of walk us through some of the basics in terms of what happens and what's the difference for a provider other than obviously facing potential jail time for a criminal conviction versus a civil violation. What are the differences and what sort of paths for restitution or repayment are available to DOJ and DHHS in the event that somebody has found convicted criminally versus civilly liable?

Mr. Jackson:

[00:29:08](#)

Well, in both the case, you're going to get an order for restitution, which means they're going to owe us the money. And any time the state pays them money, say in a tax refund, we're going to collect that. You can put liens, you can do all

kinds of things, but there is one advantage from the standpoint of financial return to the state of doing civil instead of criminal.

[00:29:26](#)

Civil can come with treble damages, criminal can't. And under state law, if we collect treble damages, it has to go to public education in North Carolina. To date, we have \$42 million for public education in North Carolina, which is more than the total state funding for MID over the last decade. We're \$2.8 million a year from the state, so, you can do the math on what we've been able to bring back just for schools in this state.

Rep. Schietzelt: [00:30:01](#)

And one thing I didn't hear you mention that I'm sure is a tool available is removal from the Medicaid program that was in your written testimony. I just want to give you an opportunity to talk about providers' removal from Medicaid.

Mr. Jackson: [00:30:12](#)

That's a very good question. So, if there is someone who is suspect, they're under investigation—a provider for fraud—we do not have the authority to turn off the spigot and end payments. That is NCDHHS. Now, we may make a recommendation to them about what occurs, but technically, that is their discretion.

Rep. Schietzelt: [00:30:31](#)

So, DHHS makes that determination. I assume that requires significant coordination between DOJ and DHHS to ensure that happens. Is there any awareness—and this question could be to either of you—of how many providers who have been determined civilly liable or have been criminally convicted that are still able to take Medicaid patients, that are still on the Medicaid role as a provider?

Mr. Jackson: [00:31:04](#)

Again, we don't have the authority to end Medicaid payments.

Rep. Schietzelt: [00:31:07](#)

That's why I opened up the floor to either of you gentlemen.

Mr. Sangvai: [00:31:11](#)

So, in order for a provider who's enrolled in Medicaid to be disenrolled from Medicaid, there are really two pathways. The managed care organization can remove the provider from their network. And the MCOs actually have two ways to do it. They could do it for cause, such as having a civil judgment or criminal judgment against them. The MCOs also have the ability to do it for convenience.

[00:31:38](#)

And so, if you have a provider in your network who just isn't playing by the rules of the game, someone who is not following up with timely remittance of information, submitting their

quality data and so forth, so, there is a rather liberal opportunity that exists at the MCO level to remove a provider from a network. At the agency level, we have the ability to do that as well. And so, we can look at primarily [for] cause at the agency level.

[00:32:06](#)

So, we can't remove for convenience, but we can look for cause. So, if, for example, we hear from MID, we have this provider that's indiscriminately doing something and is leading toward a criminal or civil prosecution, we have the ability to remove that person from the entire Medicaid network.

Rep. Schietzelt:

[00:32:22](#)

Let me go ahead and ask the question maybe a little bit more directly then. I appreciate the answer and the information. Do we have confidence as a state right now that anyone who has been found civilly liable of Medicaid fraud or has been criminally convicted of Medicaid fraud is no longer able to accept patients and receive Medicaid payments?

Mr. Sangvai:

[00:32:44](#)

So, our confidence would come from the fact that that pay provider can be suspended. So, there may be a network. There's a difference from being in the network. So, if you go in and look in the network, what would the name be there? But could there be some action against the provider that's not allowing to submit claims? Absolutely.

Rep. Schietzelt:

[00:32:59](#)

So, again, let me try to be just a little bit more direct, and I'm sorry to keep... I want to know, are we certain that anyone who has been convicted or found liable for Medicaid fraud is no longer able to accept Medicaid patients? Because a lot of the focus of what we're looking at and the questions that we have today are about inter-agency communication.

[00:33:21](#)

This is obviously a large undertaking, and we want to make sure that things are running efficiently. Do we have confidence that the names of the providers who have been found liable or who have been criminally convicted, that those providers are no longer accepting Medicaid patients and accepting Medicaid reimbursements?

Mr. Sangvai:

[00:33:39](#)

I appreciate that question. We can have confidence, yes. Now, the way to determine that would have to go and actually look at the individual provider and their status within the Medicaid program. So, if there is a provider out there that has some level of judgment against them, and then the roster would say they're in network—being in network and being able to

continue to see patients are two separate things—your name may still be in-network, but your ability to actually submit medical claims via Medicaid may be suspended.

Rep. Schietzelt: [00:34:09](#) Thank you. And just one last question, Mr. Chair. And I want to go back to the Attorney General. This is probably somewhat of a softball, but would it be beneficial for the Department of Justice and the fine attorneys that we have at the Department of Justice and MID to have the independent prosecution authority rather than having to hand these over to local DAs to prosecute other instances of fraud?

Mr. Jackson: [00:34:37](#) Okay. That's a really good question because the AG in North Carolina, all AGs are vested with very different authority. It just so happens that the AG in North Carolina, to your point, has extremely limited criminal jurisdiction. Civil jurisdiction very wide, criminal very narrow. And that applies to Medicaid fraud.

[00:34:55](#) But what happens anytime we get a referral for Medicaid fraud and we turn it into an investigation, we think there's good evidence, we call the DA and we offer the case to them. And what we say is, "We have national experts in this, and we're happy to handle it, and we have a very good track record, or you can." And you know what they say? They say, "You got this." So, that alone would not be helpful. Here's what would be helpful: We have federal partners on a lot of these cases. Some of them send us tips. A lot of them are federal prosecutorial partners. Three US attorneys in North Carolina.

[00:35:32](#) We have people in our MID that we pay working in all of those offices with Dan Bishop, with Russ Ferguson, with Ellis Boyle. It's a great working relationship. The reason why our criminal Medicaid fraud cases have to go federal is because they have real sentences. They can get real time. Under state law in North Carolina, they can't. It's an H or an I, which is the lowest level felony, which means no time. We would love for this body to take a look at giving us the ability to prosecute people in state court and have the same leverage that we do in federal court. And I bet our federal prosecutors would appreciate it too.

Rep. Campbell, Chair: [00:36:23](#) Thank you, Representative Schietzelt. I'm going to take a moment. A common theme when we're asking for oversight and accountability, it seems like the request is always more funding and that's going to fix everything. I'm just going to give a couple of examples, and I'm going to kind of ask a couple of questions about it and then I'll share how we came about this.

So, I'm going to start with an ongoing investigation related to Medicaid.

[00:36:55](#)

In October of 2025, the US Attorney's Office accused Cedric Dean and other conspirators of healthcare fraud in the form of exchanging hotel rooms, meals, or gift cards to homeless North Carolinians in exchange for using their Medicaid IDs to charge outlandish fees for substance abuse care, counseling, and services under the Certified Peer Support Services Plan.

[00:37:25](#)

Authorities moved to seize several assets from him, including three vehicles and two personal homes of Mr. Dean as well as two motor homes that were allegedly used to recruit homeless victims to give up their Medicaid IDs. In just nine months, Cedric Dean Holdings billed Medicaid almost \$15 million and had already received almost \$9 million in payment. Mr. Dean was convicted of robbery and served five years in prison, and after being released, he was convicted of selling cocaine and served 20 years in prison, only being released in 2017.

[00:38:07](#)

On his LinkedIn profile under education, he claims the credential of, and I quote, "Thugologist," in the field of, and I quote again, "Thugology," with the educational institution he received his degrees as the "Federal Bureau of Prisons." Just a few years later, after a brief pit stop as Congresswoman Alma Adams' guest at the State of the Union address in DC, he's allegedly exploiting homeless people in our state and raking in millions of dollars from Medicaid.

[00:38:45](#)

This question goes out to both of you. Beyond the accusations, let's just focus on the background. This is not a recipient. We can all agree. This is not a beneficiary. This is a provider. Can we agree on that?

Mr. Jackson:

[00:39:01](#)

Based on what you told me. Yes, sir.

Rep. Campbell, Chair:

[00:39:02](#)

Okay. How does someone like this get credentialed to bill North Carolina Medicaid for services at all? And how was millions of dollars of billing not recognized as a problem? And I ask you that, knowing there's an ongoing case, but we often use the word "we" very loosely. And this seizure was initiated by the Federal Bureau of Investigation as being pursued by federal prosecuting attorneys. How do we credential someone like that to collect money from Medicaid?

- Mr. Sangvai: [00:39:39](#) Thank you, Chairman Campbell, for bringing up that question. I'm very troubled by the Cedric Dean case for the very same reasons that you outlined. We use a centralized credentialing process in Medicaid. It's one of the things that allows us to ensure that if a person wishes to be a provider in the Medicaid program, they go through a centralized process. Including in that is all the elements of a background check.
- [00:40:03](#) A criminal conviction in and of itself does not prevent somebody from being a Medicaid provider. For example, if someone had a conviction for a minor crime a decade ago that has since rehabilitated and so forth, maybe since after that, gone to medical school and become a provider, that wouldn't eliminate them from the network.
- Rep. Campbell, Chair: [00:40:23](#) Can I interrupt you for one second?
- Mr. Sangvai: [00:40:24](#) Sure.
- Rep. Campbell, Chair: [00:40:24](#) Just so any of the things that you talk about being rehabilitated and becoming a provider, has he met any of those? I'm pretty sure I went to medical school, as did you, and I do not remember a specialty of thugology.
- Mr. Sangvai: [00:40:41](#) That's right. Right. We are looking into how Cedric Dean actually became a credentialed provider. I will say that when he became a credentialed provider, the signal that he was engaging in inappropriate behavior actually came through that first filter that I mentioned earlier through the managed care organizations.
- [00:40:59](#) And so, while a lot of what we hear about this case involves federal authorities and others, the signal that started the whole process was actually a managed care organization that had discovered this billing pattern. So, in some way, it validates that we have a good filter in place as it relates to the credentialing component that you outlined, it's an opportunity for us to ensure that all those elements that we need to check and double check are part of the credentialing process.
- Rep. Campbell, Chair: [00:41:26](#) And a follow-up to that question, some of these billable services, and I'll go back to the certified peer support services—are we not concerned that some of these are written so vague that it almost invites fraudulent activity where to be credentialed as a certified peer support counselor, you have to meet criteria that are things like "lived experience and

familiarity," is there concern in services like that that we're just softening the landings on for fraud?

Mr. Sangvai:

[00:42:02](#)

I appreciate that question, sir. The concern is when individuals take advantage of well-intended programs and services. So, if we look at certified peer support specialists, these are a group of individuals who are appropriately trained to use their lived experience and their learned experience to help individuals who are transitioning through problematic periods, whether it's leaving the justice system, dealing with their own trauma and so forth.

[00:42:29](#)

There's fantastic data that shows when certified peer support specialists are used appropriately, they actually can decrease downstream utilization. A great example is the ED for example—having somebody to call instead of saying, "I'm having a panic attack or worried, I'm going to go to the ED." Those are the confines in which study after study has been able to demonstrate that you actually get return on investment for certified peer support. Where you don't get returns, sir, is just what you outlined, when people start taking advantage of those.

[00:42:58](#)

So, we've already moved in front of this. We will be submitting a clinical policy, clinical coverage policy change specifically around certified peer support specialists with an intent to implement as soon as possible with this idea that they're going to have to be tighter guardrails. And those guardrails could be around the type of services, the type of credentialing that's required, the units of service available to the individual.

[00:43:21](#)

We don't want to eliminate those that are actually benefiting from it, but we want to make sure that there aren't individuals who can take advantage of it. And I think that's the theme we're seeing, sir, here, is we've got all these great well-intended ideas and bad actors are now determining, "How do I figure out my opportunity to exploit that?" And I would say that the one thing we need to do as an agency is to be one step ahead now. We've got to figure out how to be one step ahead of the bad actors.

Rep. Campbell, Chair:

[00:43:48](#)

You and I are in agreement on that because "if" is a word that we need to stop using so much. I understand the data related to this service. I understand what the program can be, but that's if it's done appropriately, if it's got proper oversight. If my grandma had wheels, she'd be a bicycle. I'm not as much concerned about the goal as the execution. I'm going to go

through three examples here, and I want to emphasize these are not active investigations. I'm not making a definitive accusation of fraud, but let's go. First, are you familiar with a provider named Savin Grace II? No "g," Savin Grace II.

Mr. Sangvai: [00:44:36](#)

No, sir. I did not know who that is.

Rep. Campbell, Chair: [00:44:39](#)

Over a two-month period, they billed Medicaid approximately \$400,000 mainly for long-term behavioral health, and this represented over \$16,000 per beneficiary. Based on their filings, this is their headquarters that I'm putting the slide up on the screen for review. \$400,000 in two months, long-term behavioral health. Second, are you familiar with a provider named Creative Directions?

Mr. Sangvai: [00:45:15](#)

No, I'm not, sir.

Rep. Campbell, Chair: [00:45:17](#)

Okay. They billed approximately \$2.7 million over a one-year period for counseling, substance abuse, psychosocial rehabilitation, among others. Under their official filings, they listed \$100,000 in travel expenses in one year, \$214,000 in cash and ATM withdrawals without designating the recipients, and awarded a \$76,000 individual grant to a recipient listed as first name "unknown," last name "recipient." Their charges for a beneficiary are almost four times higher than the average. Last example, are you familiar with Wilson's Home Care?

Mr. Sangvai: [00:46:05](#)

No, sir.

Rep. Campbell, Chair: [00:46:06](#)

They have billed Medicaid \$12 million over a six-year period for home care services. Based on their filings, this is their Mayfield headquarters, the slide that you see. You can see their operations set up through the windows here, and if I could go to the next slide of the same property. I'm a big advocate for patient privacy, but boarding up windows is a strategy I really haven't seen before.

[00:46:37](#)

Now, to be fair, they do list a second location in Mayfield, which is the last slide. I want to repeat, none of these three examples have official charges of waste or fraud. My point here, we keep talking about how we have no money to look into this. If we only gave you more money.... These examples and multiple others, we had two staffers with Google and an Excel sheet in less than two hours came up with these figures, these filings, and these locations.

[00:47:16](#)

Do these examples not give you both some thoughts that they should be looked at closer or make sure taxpayer money is being used for valid services? We often get the reply that the department needs more money to investigate, and I'm open to that discussion, but we did this in 90 minutes. Can we at least all agree that there's much more that we can do to ensure this money is being used appropriately? And I'll leave that to both of you.

Mr. Jackson:

[00:47:51](#)

My answer is yes. And Representative, I think you just made an excellent case for why we should double down on data mining because while all of that was compelling, none of it survives a grand jury. None of it is sufficient.

Rep. Campbell, Chair:

[00:48:06](#)

I'm just going to interrupt you for a second. I get that. I'm three years from a law degree, okay? I'm not asking do we convict based on that alone. We can look at things, and we can say there's a simple explanation for this. We can disagree on what's fraud, we can disagree on what's waste, but what we cannot agree to do is not look. Can we at least agree that that should get your interest?

Mr. Jackson:

[00:48:37](#)

Yes. Now here's how we solve the problem given that we have, in the state: 115,000 Medicaid providers. We are not going to, at scale, in the way that the taxpayer deserves, crack down on fraud by using Google search images. We're going to do it with data. I want to crack down at scale, and I'm telling you the way to do it is to focus on data mining. We are already the national leader in this.

[00:49:13](#)

The major prosecution, the biggest Medicaid fraud conviction that has happened so far in North Carolina this year began with our data mining unit, which is again, in its infancy. All of what we just saw, all of those images make the case for investing and combing through data to look for two things in particular, the telltale signs: upcoding and phantom billing. Because, just as I said, none of that would survive a grand jury.

[00:49:40](#)

I'm not telling you that you can't get a conviction based on that. You can't get a charge. I'm telling you how we can get charges. The way we can get charges is by investing in data mining so that I can show a grand jury telltale signs of upcoding and phantom billing.

Rep. Campbell, Chair:

[00:50:03](#)

I'm going to change order just a little bit. I'm going to recognize Representative Johnson next.

Rep. Johnson: [00:50:09](#) Actually, Mr. Chairman, Representative McNeely, I believe, has to get to another oversight meeting. So, if you would indulge maybe him jumping in and asking his questions, then we'll circle back because I do want to talk about the data mining too. That's extremely fascinating stuff going on. Representative McNeely.

Rep. Campbell, Chair: [00:50:23](#) Chair recognizes Represent McNeely.

Rep. McNeely: [00:50:25](#) Thank you, Mr. Chair. Thank you, committee. Thank y'all for coming today. I do have a couple questions. We've heard great, compelling drama here of how we're really trying, but the words aren't really following, in my opinion, the path that we're seeing. Attorney General Jackson, and I know you haven't been here the three years I'm going to mention. You've been here a little over one. Can't remember the guy that was before you, it's on the tip of my tongue.

[00:50:52](#) Anyway, referrals to your office have increased about a third, but the rate in which your office actually opens investigations has dropped from around 25% down to around 15% from the numbers that we have been given. And let me go back to this. It says here in one of your opening remarks you gave us, they sent back to us.

[00:51:19](#) "We are completely in line on this. There is no acceptable level of fraud in North Carolina. We must fight aggressively everywhere." Do you remember sending that to us?

Mr. Jackson: [00:51:30](#) Yeah.

Rep. McNeely: [00:51:31](#) And "at the North Carolina DOJ, we are our state's Medicaid provider, investigators, and prosecutors. We take the work very seriously, and our results back it up."

Mr. Jackson: [00:51:45](#) Yes.

Rep. McNeely: [00:51:46](#) I don't think so. And so, my question is, we've got more people reporting fraud, and we've got less actual cases, looks like being left open. So, why?

Mr. Jackson: [00:51:59](#) Those are not cases that are being left open. When we have more people reporting fraud, that could be more leads coming from NCDHHS—which tend to be pretty high quality, could be leads coming from whistleblowers—which also tend to be pretty high quality. We also have a link on the website where any member of the public can report anything, which is why it's

a little misleading to say, "Well, here are the number of tips that became investigations."

[00:52:26](#)

Here's what becomes an investigation: anything that has good evidence of fraud, whether it is one dollar or a million dollars. There is no acceptable level of Medicaid fraud, none. And I have told my team that even though we are big game hunters, and we take down a lot of big game, if we have good evidence that there is one dollar of fraud, we're going to go after it.

[00:52:55](#)

And to your question, how do you know that we really do this job well? It is because we are eighth in the nation for recovery over the last six years. We are fourth in the nation in recovery per dollar of funding we have received. That is the true metric that determines how we are doing relative to our peers.

Rep. McNeely:

[00:53:19](#)

Okay. Well, answer me this. There's over 150 cases that are over three years old. I don't know how long it takes to kill a big game. Maybe an elephant takes quite a few shots, but it seems like there's maybe more posturing going on than actual work. If we've got that many cases laid out there that are over three years old, why can't we bring them to fruition some way or another?

Mr. Jackson:

[00:53:41](#)

That's a very good question. The average case is not three years. It's much less than that. However, part of the answer is that when you get into the court system, now you're operating on their timeline. Part of the answer is, for whistleblower cases in particular, federal law controls because whistleblowers are entitled to a certain payment at the end for blowing the whistle as an incentive.

[00:54:04](#)

So, there is federal law about, when those cases begin they go under seal, and they are not allowed to come off of seal until the federal government says so, which means those whistleblower cases are artificially expanded as far as the timeline, even though they wrap up. But here's the big answer that I want to impress upon all of you: When I say we're big game hunters, I mean it. I don't know if you can tell from your vantage point.

[00:54:32](#)

I've got three black cartons here. Can everybody see these? This is from the Sims case, the one I told you about last month: biggest case this year in Medicaid fraud, \$12 million, five people went to prison for many years. These are all full of binders.

Those binders are full of paper. These three cartons represent 5% of the evidence in that case.

[00:54:57](#)

Sixty of these was that one case. That's what we do. And we do it as well as any division in the country. When people deliver evidence to us, they do it in a moving van. Our average win for these cases is \$4 million. When you have a section whose average case is worth \$4 million, that's why these investigations aren't over in a minute. We're not going after the drug dealer on the corner. We're taking down the gang.

Rep. McNeely:

[00:55:39](#)

Mr. Chairman, I'll state this, and that'll be the end. I knew about, what was it, three, four years ago when we expanded a program that was already needing an overhaul that we were asking for much, much more fraud, and we got it. We should have taken care of Medicaid and our reimbursements and our providers that were fraudulent then before we ever expanded it, but we didn't. And on the record, I voted no, and I was right.

Rep. Campbell, Chair:

[00:56:16](#)

Thank you, Representative McNeely. Chair recognizes Representative Johnson.

Rep. Johnson:

[00:56:21](#)

Thank you, Mr. Chairman. And thank you, Mr. Attorney General, for being here, Mr. Secretary. And I want to start out by saying, Mr. Attorney General, during the storm, we worked with your staff a good bit, and they were extremely responsive on consumer protection cases, and we really do appreciate that.

[00:56:37](#)

I want to start out—you had mentioned the data mining program and this falls in my wheelhouse. I chair IT here, so, it scratches an itch for making sure we are being proactive. Can you explain that program in depth, how it's prioritized, how it's driven, and anything you'd like to expand on that you started before?

Mr. Jackson:

[00:56:58](#)

I knew you were going to be my guy on this. You have a reputation for this, and that's great. So, in 2017, we became the third state to request a federal waiver from federal HHS to give us access to backend billing data. They did that. We then asked investigators to volunteer for duty on top of their full-time job to come together and form basically an ad hoc data-mining team. They did that. It has produced 68 investigations. I can't remember how many convictions, I want to say eight or nine, and tens of millions of dollars recovered.

- [00:57:36](#) More money recovered from this ad hoc team than has been paid to fund all of MID for the last decade. So, clearly, this is fruitful. Now add to that AI, which was not a tool in 2017, 2018, 2019, but is a tool now. Not general AI but specific software that exists to look for specifically upcoding and phantom billing. We would be fools not to take advantage of this. And our federal partners are giving us data. They want us to move in this direction. Other states are coming to us asking to be trained in this.
- Rep. Johnson: [00:58:14](#) Well, and I know that ours is federally recognized. Ours is federally approved. What is the difference? Are some states doing it that do not have that federal designation or do not meet that criteria?
- Mr. Jackson: [00:58:25](#) If you don't have a federal waiver, you don't have access to all the data. So, they may have partnerships with MCOs or their version of MCOs, and MCOs themselves do data mining, and they have a financial incentive to do that. And that's great. They're good partners, but they don't have all the data.
- Rep. Johnson: [00:58:43](#) Perfect. And looking through—and I believe this was in a federal submission is where I read it—I'm looking through, this is signed by your office. The total data mining costs for 2025, or fiscal year, so biennial, were \$5,000. Is that because it was drawn as kind of drilled together and prorated from other salaries and things?
- Mr. Jackson: [00:59:07](#) When you picture 60 of these boxes as one case, and when I tell you we have 400 ongoing investigations, roughly 100 criminal and 300 civil, that's why I can't take any of those investigators off those cases because we would have a backlog. These investigations would go longer. So, what we told them was, "We're asking you to add to your full-time job to do this, which is why we're not paying for it yet."
- Rep. Johnson: [00:59:32](#) Okay. So, that's why that number's... I read that, and that's one of the questions I was asking our staff. So, is that 5,000—did we forget a zero? Is that supposed to be five million? But it sounds like it's being pulled together on top of a full-time person.
- Mr. Jackson: [00:59:44](#) And to be clear, our request for you for short session is \$44,000 because we only need 25% of the funding to get the federal government to throw in 75%. To me, that's a high ROI proposition.

- Rep. Johnson: [00:59:54](#) And really, the only question that comes from that is it clearly is a program that works. I think it's \$21 million that's generated in recoveries. I consider that extremely successful for especially a new program. It says only 131-and-a-half hours collectively, which comes out to about three and a half weeks of one employee's time, and I know it's more than one, but one employee's time for a huge \$35 billion program. Do you think that's something that we need to expand on for sure? Because it sounds like it is working when it works, but we're just not doing enough of it.
- Mr. Jackson: [01:00:31](#) I'm not asking you for the moon and the stars on this. I'm asking you for one position because I'm very confident that with that position, I can come back to you in a year and show you solid return on investment in a way that makes you see, "Oh, this is how..." We rely very heavily on external partners for referrals, and that's great. We value that. I want to generate more referrals in-house. I want to get more aggressive in going after Medicaid provider fraud. This is the most cost-effective way to do it.
- Rep. Johnson: [01:01:03](#) And looking back, and I'm going to say "you," but when I say "you," I'm referring to the office itself. In fiscal year '23, I believe there were 47 staff that had devoted about 173 hours as reported in that federal report—173 hours to data mining—as opposed to when the new positions were approved of 10 additional staff. Obviously it was the 131 hours, so that number went down. Is that better technology being used, or is that just not prioritizing as heavily as it has been in the past?
- Mr. Jackson: [01:01:36](#) I think it may have been simply a matter of personnel flux. People rotate, given that this is an all-volunteer effort right now, people rotating in, people rotating out.
- Rep. Johnson: [01:01:46](#) And we'll circle back. I know we've got some follow-ups we'll hit. But really going forward, you mentioned the AI aspect of it. We're putting it together, and we're kind of navigating the federal moratorium on AI legislation as well. But one thing that I think, and we're getting clearance on this now that we are able to legislate, is how we implement it within state agencies, how we do it. Once we have, hopefully, and I'm for this additional position to help because it seems like if we had, frankly, if we had the manpower, we could generate more recovery on it. And if we were able to implement some AI technology that this person could use, so, not eliminating this position, still adding the position, do you see that number when we have another

one of these, and maybe next year or the year after, do you see that number of recoveries going up if we're giving you the tools? And how do you expect that to grow?

- Mr. Jackson: [01:02:41](#) I do. I mean, looking at the amount of data that we knew we have access to, looking at the new AI software that we have access to, and just looking at the sheer number of Medicaid providers in the state, the answer is yes.
- Rep. Johnson: [01:02:55](#) And really, I'm looking at the number of ones that have been found and are still open. And I think you alluded to this in another question. Of the number, I believe there's 154 cases that have been open for over three years. And again, you weren't there that entire time, but why are some of these cases still open? Is it just lack of evidence to take it to prosecution, or is it how they're prioritized, the ones that have been found?
- Mr. Jackson: [01:03:25](#) Some of those cases are still in the process of investigation, and some of those cases are in the process of litigation, which is where things really slow down because we're talking about...
- Rep. Johnson: [01:03:33](#) So, they're still considered open if they're currently being litigated-
- Mr. Jackson: [01:03:36](#) That's correct.
- Rep. Johnson: [01:03:37](#) ... through your department. And going forward, I'll circle back, but just one, thank you for the efforts you're doing as far as that. And we'd love to work with your office going forward on that AI piece of it, because I think adding a position is good, but the sheer capacity of data you are working with in the stream is... just positions alone and throwing money at it aren't going to fix it. We have to put better systems in place to catch this stuff on the front end. And this is coming from someone who voted no. I was another one of the no votes on Medicaid [expansion]. I didn't think there was enough guardrails in at the time. There was no work search requirement at the time. And the federal CMS, if I remember, said there can't be work search requirements. I didn't agree with that. I said, "I think there's a good case to be made in court that someone working two jobs and really working shouldn't be getting the same benefits as someone who's not even actively looking."
- [01:04:32](#) I just didn't think that was the right thing to do, and it invited fraud in these systems, but we passed it. We are where we are today. We're not going to go rehash that. But going forward, I

think just based on the cases that Dr. Campbell mentioned, we have to keep being proactive in finding these things, not reactive. So, thank you so much for being here and for the work y'all are doing. Thank you.

Rep. Campbell, Chair: [01:04:55](#)

Thank you, Representative Johnson. Chair recognizes Representative Reeder.

Rep. Reeder: [01:04:58](#)

Thank you very much, Secretary and Attorney General, for being here today. I think the theme of this is that we've seen what's happened in other states, Minnesota and California, where there's been tremendous fraud with millions and billions of dollars. And I think what you're hearing from the committee today is [a request for] assurances that North Carolina is not going to find ourselves in that same boat. So, I have some questions about that in a minute, but one of the questions for the secretary is, in the fall, we had heard a lot about Medicaid, and the department cut reimbursement rates for providers across the way. And that was argued that that was because we're going to run out of money, and we'd heard at the time April was going to be the time. As we fought those in court, and there was a lot of allegations of violating law in those cuts, where are we today? Do we have enough money to pay the bills?

Mr. Sangvai: [01:05:51](#)

Thank you for that question, Representative Reeder. We've forecast our monthly expenditures in Medicaid and are able to do it on probably a one- to two-month lag. So, we're in the process of looking at where we are at the end of February and March at this point. Our monthly assessment of where the Medicaid program is going to be in fiscal '26 is still projecting a \$319 million shortfall. That's largely based on the analysis we've done that will take into consideration ongoing utilization patterns that we've seen so far throughout the year.

Rep. Reeder: [01:06:25](#)

Do we still think we're going to run out of money?

Mr. Sangvai: [01:06:28](#)

In the absence of an appropriation, we will run out of money.

Rep. Reeder: [01:06:32](#)

When do we anticipate, do you think?

Mr. Sangvai: [01:06:34](#)

Right now, the forecast is in May.

Rep. Reeder: [01:06:36](#)

Thank you very much. Turning to the idea about detecting fraud and waste, do you feel like the department has enough tools

and is being as proactive as they can in the identification of fraud, waste, and abuse?

Mr. Sangvai:

[01:06:51](#)

Thank you for that question, Representative. It may help to give a little bit of a high-level overview of the department and how it tackles fraud, waste, and abuse. So, as I said earlier, the sentries at the gate for us are those managed care organizations. Those managed care organizations are required—they're contracted to identify fraud, waste, and abuse. They're supposed to have special investigative units that are then designed to investigate any allegation of fraud, waste, and abuse. So, to go back to those three examples that Dr. Campbell had shared earlier, in addition to data mining, those are the type of examples that the managed care organization should be able to find using their tools and techniques. Remember, we have managed care organizations—some that have a national footprint that can bring the entire capacity of what they're able to do to be able to identify FWA in the Medicaid component of their program.

[01:07:43](#)

So the first line of defense for us are the managed care programs. Second line of defense for us is our ongoing internal process on identifying fraud, waste, and abuse. Some of that is signaled by when the MCOs tell us, "Hey, we have identified someone for suspected fraud, waste, and abuse." But it's also an opportunity to convene all of them to be able to understand what they're seeing on a regular basis, to identify providers that one MCO may have found that another MCO has not found that's conducting that same type of behavior. So, we have a second layer as well.

[01:08:16](#)

So those two layers have really allowed us to identify the fraud, waste, and abuse components. We're also looking largely informed by what the Attorney General's office is doing with technology tools that we may be able to deploy. On top of that, additional tools that we can use that will then help us think through not only those things we're seeing, but maybe even getting a little proactive using artificial intelligence and other tools that will then allow us to say it's not just looking at what has happened, but can you then use predictive analytics, for example, to say where are those potential risks? So, to answer your questions, we have tools. I can't say with certainty we have every tool we want right now, but we're going to explore within the resources we have to see how we can bolster the tools that we currently have.

Rep. Reeder: [01:08:59](#) And thank you very much. And we've talked about the PHPs, and they're not in front of us right now. What's the requirement, and are the PHPs doing their job? Because if they're supposed to be the front line of protecting the taxpayer money and they're doing a bad job, because for them, they're going to pay the claim, and there's no harm, no foul to them. Do we have a tool if the PHPs aren't doing their job, or how do we assure that they view that as an important role as you've described?

Mr. Sangvai: [01:09:30](#) Yeah, thank you again, Dr. Reeder. I want to take a moment and say we have a really strong working relationship with our PHPs, and I don't believe they are ignoring this in any way or dismissing the importance of fraud, waste, and abuse. The tools we have available are an audit process that we actually run on the managed care organization's fraud, waste, and abuse process. We use a third-party vendor that helps us determine, are they doing what they need to do? One of the opportunities, however, is something called prepayment review. We've talked up until now about how to get money back when someone has been given money they don't earn, but we have a remarkable tool called prepayment review, and any plan can put any provider on prepayment review. It is not an adversarial action. It is not an action that the provider will then have to report to any licensing authority or anyone else.

[01:10:27](#) And here's how prepayment review might work. If I'm a planner and I'm noticing, "Hey, there's a doctor out there that's billing a few more of these higher-complexity codes that don't make sense relative to their peers," the plan can say, "We're going to put you on prepayment review." What that's going to allow us to do is to help us better understand your practice because it may be legitimate that you have more highly complex patients and so, you're submitting more complex claims. So, prepayment review is a wonderful opportunity to prevent any situation from people getting money. At the same time, it can serve as an educational tool. There is no requirement for a plan to seek the agency's approval to put a provider on prepayment review that is contractually within their whole right to do so.

Rep. Reeder: [01:11:14](#) Thank you very much. You mentioned before about having access to the data. So, the PHPs have their limited claims, but they don't have the totality. Only the department has that. As you're just thinking about prioritization, is there a way that you can look globally because it might be that each plan, there's someone just a little bit out of compliance or out of the bell-

shaped curve, but in totality, then they really jump out? Can you describe some of that? And does that go into that? We got some data about a matrix that you have for looking at that. Is that how that works?

Mr. Sangvai: [01:11:50](#) We do. So, in addition to getting the signals from the MCOs on fraud, waste, and abuse, we can do exactly what you outlined, sir, and look at all the data in aggregate because you are right, there could be a provider in one plan that's behaving one way that's not behaving the same way in another plan, or two plans that have independently identified the same behavior that have not had an opportunity to connect. So, we have the opportunity to aggregate all those claims, validate that those types of behaviors are happening. And then when we do signal, one plan is saying, "You've got this one provider potentially on prepayment review that's not practicing within what we would be expecting to see in terms of regular standards," then we are able to communicate to other plans about that provider.

Rep. Reeder: [01:12:32](#) Do you have enough in your department to be able to do this type of detection? And again, we're not looking for you to say we need more people. Because as we heard before, that's where everybody goes, but additional tools that they might share with the Attorney General.

Mr. Sangvai: [01:12:51](#) Yeah, absolutely. And I appreciate that, Representative Reeder, because I was going to go into that mode on saying we need more resources. And I'm not saying that's not the case, but in this particular situation, I think what we have an opportunity to do is to think about the way we're doing the work, what are the technology tools that we layer on top of it. Technology isn't always cheaper, but you can get more bang for the buck sometimes when you're doing that. I think the other thing that technology is going to allow us to do that I mentioned earlier is get ahead of things so we're looking at things proactively and not retroactively.

Rep. Reeder: [01:13:24](#) Thank you very much.

Mr. Sangvai: [01:13:25](#) Thank you.

Rep. Campbell, Chair: [01:13:28](#) Thank you, Representative Reeder. Chair recognizes Representative Miller.

Rep. Miller: [01:13:32](#) Thank you, Mr. Chair. Thank you, gentlemen, both for being here today. And my question is for Attorney General Jackson.

Mr. Attorney General, do you know what percentage of fraud referrals your office receives comes from private citizens—regular people calling in tips—versus referrals generated by DHHS's own fraud detection work?

Mr. Jackson: [01:13:53](#) I don't know the exact percentage, but I do know that as a category, the biggest category of tips that we get is from private citizens, but that conflates two different groups of private citizens. One is members of the general public—get lots of those, but the other is whistleblowers. According to our reporting metrics, whistleblowers are categorized as private citizens, and that can skew the referral stats a little bit.

Rep. Miller: [01:14:21](#) Okay. According to your own federal reporting, in 2025, private citizens accounted for 223 out of the 345 fraud referrals to your office. So, about 65%. DHHS's own proactive detection work, not counting cases MCOs found and just passed through, DHHS generated 22 referrals, 6%. Mr. Attorney General, the public is doing 10 times more fraud detection than the state agency responsible for the program. Does that concern you?

Mr. Jackson: [01:14:56](#) Well, I don't think that's an accurate statement. I think it is the case that we have a link on a website that is public facing, so, it gets a lot of traffic.

Rep. Miller: [01:15:03](#) Okay. All right. And the last question is, given that private citizens are already your single largest source of fraud referrals by a wide margin, would your office support making Medicaid billing data publicly available? The same way that some federal spending data has been released recently so that independent researchers and citizens can help identify the fraud your agencies don't seem to be catching.

Mr. Jackson: [01:15:28](#) Representative, I think that's an interesting question because you're right, the federal government did just make a tranche of Medicaid billing data available. We immediately set upon that, analyzing that. I think there's always a question about making sure that we're not releasing people's medical information or personal identifiable information, but as far as taking sanitized data that might help independent groups or MCOs who have an interest in doing this help us with investigation, I'd be open to considering that.

Rep. Miller: [01:15:57](#) Well, good. We can discuss that later, I guess.

Mr. Jackson: [01:15:59](#) Sure.

- Rep. Miller: [01:16:00](#) Okay. Thank you. Thank you, Mr. Chair.
- Rep. Campbell, Chair: [01:16:02](#) Thank you, Representative Miller. Chair recognizes Representative Ross.
- Rep. Ross: [01:16:09](#) Thank you, Mr. Chairman. I want to thank both of you for being here today. Trying to get closer to this mic. I want to kind of circle back, sort of back toward the beginning. Chairman Campbell in his opening statement noted that Medicaid enrollment has grown faster than the state's population. And during COVID, the state was not allowed to verify eligibility or risk our higher federal reimbursement rate at that time. That led to 500,000 people being added to the Medicaid roles. And my question is, how many people have since been found to be ineligible for Medicaid due to income or other factors?
- Mr. Sangvai: [01:17:05](#) Thank you for that question, Representative Ross. Let me frame it in two contexts before I specifically answer that question. The Medicaid program that we have in North Carolina can be categorized as an expansion population and a non-expansion population. The expansion population is the result of the '23 action of the General Assembly that increased the income eligibility requirement to be accepted into Medicaid. Around 725,000 North Carolinians are now on Medicaid as a result of expansion. Just a couple other quick points on expansion because they're important to be able to determine between the two buckets: Expansion is a partnership that we have with the federal government and the hospitals in terms of how to finance. So, as we talk about rebase today, it'll be important to continue to get back and talk about the non-expansion population. And what you're largely referring to is the non-expansion population. Those are individuals who become eligible for Medicaid because they meet the income threshold that's even below the expansion population.
- [01:18:06](#) They're children, they're elderly sometimes dually enrolled in Medicaid and Medicare, and members of our IDD community. Those individuals make up—and that's roughly about 2.4 million North Carolinians. During COVID, the federal government mandated that the redetermination process, which is an annual process presently—soon to be semi-annual—where data points are taken in to make sure that a beneficiary who's currently receiving Medicaid continues to receive Medicaid, the mandate from the federal government was to suspend that. And so that was the continuous coverage during the Medicaid period, which you're referencing, where people who were on Medicaid stayed

on Medicaid. Since then, there's a process that we've called CCU, or continuous coverage unwinding, where that's no longer applying and that individuals who are currently on Medicaid are being evaluated for their ongoing eligibility for Medicaid. The continuous coverage process that started during COVID has now been completed, and there's no one who is routinely considered eligible for Medicaid as a result of CCU.

[01:19:14](#)

To your question about how many: on average, during the redetermination process, about 5% of the individuals who are currently on Medicaid will fall off of Medicaid. And as we look at the projections in that non-expansion population, we are anticipating that that non-expansion population will actually decrease over time. So, if one of the measures of the Medicaid program are the number of people who are in the program, we're actually forecasting a decrease in that non-expansion population. The final thing I'll say is that I'll go back to eligibility. In that non-expansion population, we have children; we have older adults; we have individuals of the aged, blind, and disabled community; and others. So, the ability for those individuals to come off Medicaid because of those eligibility criteria are less likely than some of the others. So, to summarize, around 5% fall out every time during a redetermination process, and that continuous coverage process, which began in COVID, has now been complete.

Rep. Ross:

[01:20:15](#)

Thank you. That kind of seems like a little bit of a small number in a program that enrolls roughly three million people. What percentage are deemed eligible *ex parte* federal regulations and so forth?

Mr. Sangvai:

[01:20:36](#)

So just to clarify, the way the *ex parte* process works is that there are roughly, again, 3.1 million North Carolinians who need to redetermine for Medicaid every year. An important point is that this work all happens at the county level. So, each county is responsible for redetermining the members that are in Medicaid in their county. Counties are given a number of tools to be able to help expedite the process. I don't have to remind anyone that the counties are facing some of the same challenges we are in terms of labor, workforce, demand on time. These are the same individuals who are doing the work in CPS, adult protective services, food and nutrition, and so forth. So, giving them efficiency tools is an important thing to be able to allow them to make that redetermination process work. *Ex parte* is when external data are used to help validate that a criterion is being met.

[01:21:32](#)

Think of it as a bunch of pings. If there is a series of pings that need to occur, external data, if it pings an individual's address, income, and so forth, those all count as pings, for lack of a better term, during the redetermination process. Around 67% of individuals who go through the redetermine process will have every ping hit such that a human then won't need to go back and then validate. About a third do not have every ping hit. So, while they may have *ex parte* data used, a human will need to go back and validate it. So, it's about two thirds that can be redetermined through the *ex parte* process, and one third requires a human intervention. And I'll remind everyone again that when you think about the eligibility criteria, particularly age, blind, disabled, and children, those statuses aren't going to change in individuals, which is why *ex parte* makes sense because if someone is income eligible, that may change over time.

[01:22:44](#)

If someone is a child that's three years old, it's not going to change over time. So, that's where *ex parte* helps. It's a balance between convenience using technology, but there's always a human overlay if the *ex parte* process finds anyone who has an eligibility criterion that doesn't match.

Rep. Ross:

[01:23:04](#)

Thank you. Let me ask you this: How do federal rules promote the *ex parte* process?

Mr. Sangvai:

[01:23:12](#)

Yeah, there are a number of federal rules and obligations that require us to use *ex parte*. There are also federal rules that require us to take data that may come through healthcare.gov. So, our balance on the guidance, again, that we have to give to counties is in large part based on what the federal government requires us to do and ensuring that we're following those rules as we're giving guidance to counties.

Rep. Ross:

[01:23:41](#)

Thank you. Let me ask you this: How does DHHS incorporate the bias toward finding people eligible for Medicaid and expanding enrollment into NC FAST and other practices and processes?

Mr. Sangvai:

[01:23:59](#)

In order to identify someone who's eligible for Medicaid, I want to make sure I understand your... I think I understand your question, sir. To be deemed eligible for Medicaid, an individual would reach out to their county DSS office. That county DSS office will use a number of tools, including NC FAST, to determine whether or not that person is eligible. If they are eligible, then they move forward through the eligibility enrollment process. If they're not eligible, they're simply not

eligible. So, the NC FAST system is designed to help provide data and other signals to the agency or to the county to be able to make the determination as to whether or not someone is eligible for the program.

- Rep. Ross: [01:24:45](#) Thank you. Does Medicaid independently verify eligibility of people recommended to the program from the Federal Health Insurance Exchange?
- Mr. Sangvai: [01:24:55](#) Right now, the federal rules require us if the federal exchange... My understanding is if the federal process requires us to... The federal process requires us to accept anybody that the process deems to be eligible for Medicaid. So, if the individual signs up, attempts to sign up, let's say for an ACA plan through healthcare.gov, is later deemed to be Medicaid eligible, then the current rules require us to accept the Medicaid eligibility as determined through that process.
- Rep. Ross: [01:25:30](#) Thank you. It's not really a question—this is an observation that having tens or hundreds of thousands of extra people enrolled leaves the program more vulnerable as we come under federal funding pressures, as federal funds are cut. And I think that's something we need to be aware of and cognizant as we continue to enroll individuals to the program.
- Mr. Sangvai: [01:26:09](#) May I offer a response because I think you raised...
- Rep. Ross: [01:26:11](#) Creates a lot of vulnerability. Yes sir.
- Mr. Sangvai: [01:26:13](#) You raise a really interesting point, and I think it's something that's impacting every healthcare provider and every healthcare plan and insurance system in the country. As we have processes that allow individuals who are able to leave the Medicaid program or leave any insurance program, it's largely because they are not sick or as sick. And what we end up having are insurance pools of individuals who are sicker. So, one of the challenges we will have over time is those individuals who are losing Medicaid on a per capita basis are actually costing the system less. And then what you're left with are individuals who, for all the reasons that are very rare and appropriate, their clinical status are costing more. And so one of the things we need to, I think, grapple with more broadly, and Medicaid is in many ways the canary in the coal mine, is the reality that healthcare costs are going higher. And as we find ways to make people healthier, there is still a group, a cohort of individuals who are getting sicker over time.

- Rep. Ross: [01:27:20](#) Thank you for that.
- Mr. Sangvai: [01:27:21](#) Thank you.
- Rep. Campbell, Chair: [01:27:23](#) Thank you, Representative Ross. Chair recognizes Representative Ager.
- Rep. Ager: [01:27:29](#) Thank you, Mr. Chair. And thank you very much, Secretary Sangvai and Attorney General Jackson, for being here and for all the work you're doing on behalf of the North Carolina taxpayers. I really have sort of one big question. I'll ask it all at once. There's probably a couple in there, but we've seen a lot of high-profile cases in the last couple of years and not only in Medicaid but in other things as well. And really, I think I'd like to focus this question on DHHS and Director Sangvai. But we had a case of Balanced Nutrition, a nonprofit owned by our former lieutenant general, or lieutenant governor, sorry, Mark Robinson. And as I was looking at that case here, obviously is in the news. And as I was looking at that, it really came up that I don't understand why there's been a judgment—it's happened, but that money has not yet been recovered.
- [01:28:24](#) And so, really getting an understanding, first of all, kind of how DHHS comes to those determinations, and then how that judgment is enforced over time is something that I'd like to better understand.
- Mr. Sangvai: [01:28:41](#) Thank you for that question, Representative. A number of the recoveries that are due back to the Medicaid agency are largely through processes run through the Attorney General's office. So, we really look at the tools and the techniques they have to be able to recoup any funds. What I can say is that we will use every tool and technique available to us when anyone owes us any funds. And as you outlined what... You referenced programs outside of Medicaid specifically, but we use that same mentality for any of the other programs that we're responsible for. It goes to say we have zero interest in wasting taxpayer dollars, whether it's state dollars or federal dollars, we want to make sure we're getting maximum value for that dollar. And if one of the ways to represent getting maximum value for the dollar, if there are individuals who have been inappropriately paid or taken the money from the Medicaid program or any other program under the jurisdiction of DHHS, we'll use every tool and technique to get that dollar back.

- Rep. Ager: [01:29:42](#) Thank you. And I understand that. I mean, I guess my real question is, over time, if somebody doesn't pay that money back, and it seems that in some cases that happens, and we can find them—but what are the legal repercussions? I mean, if somebody doesn't pay back the \$100,000 that there's been a judgment against, is that something that we can continue to push for?
- Mr. Sangvai: [01:30:10](#) Again, we will do everything we can to push for it, but there is a reality at some point that there are going to be dollars that are aged that for a whole host of reasons you'll not be able to recoup.
- Mr. Jackson: [01:30:25](#) There is a difference here between the civil and the criminal order for restitution. Criminal order for restitution means you are potentially hanging jail time over their head. Not the case, by the way, in this specific instance. Civil restitution, if people don't pay, then there are a number of civil levers that the state can pull, but you can't threaten them with jail time.
- Rep. Ager: [01:30:46](#) Thank you. I really appreciate it.
- Rep. Campbell, Chair: [01:30:49](#) Thank you. Chair recognizes Leader Reives.
- Rep. Reives: [01:30:54](#) Thank you, Mr. Chair. And I think some people here would say I'm three years also from a law degree, even though I've been practicing law for 30 years.
- [01:31:06](#) And I appreciate the distinction you just had. I appreciate both of you being here. I will not pretend to be an expert, even though a lot of times when we get elected, we become experts. I've not had that benefit in what you do. What I thought I heard a while back in this discussion when we were talking about, "Well, what do we do about some of these groups that seem like they're a little fishy?"—the managed care organizations seem to have a lot of latitude in deciding who they take on. Am I correct in that?
- Mr. Sangvai: [01:31:41](#) Yes.
- Rep. Reives: [01:31:42](#) So, no matter what you guys do, if the managed care organization says, "Hi, this guy looks a little funny. I'm not real sure if we ought to let them start doing Medicaid or taking Medicaid patients," do they have the right presently under the law to just say, "I'm not going to do it?"

- Mr. Sangvai: [01:32:01](#) Yes. Thank you for that question, Representative Reives. The primary tool that the managed care organization can use is something called prepayment review. And the way that works is when a provider submits a claim, the claim is then held for edits and other validation by the managed care organization. So, it's not so much what the provider won't do, it's what the provider won't get. They simply will not get paid if they're in prepayment review, if they're not participating and following up with any additional data or anything else that the managed care organization is offering. So, their inaction leads to nonpayment.
- Rep. Reives: [01:32:43](#) Got it. Okay. And with these managed care organizations, because these are kind of new since I got here and not new overall, but I'm just saying when I got here, I think we were kind of under a different system and they developed. Who decides what groups get it? And the reason I'm asking is, for instance, I would use- Cardinal at one point was a managed care organization. There was a lot of fraud and abuse, and so, they seem to have disappeared is my understanding. Who decides that? Does DHHS award those contracts? Is the General Assembly involved in that? Who ultimately decides these will be the four or five managed care organizations that run the state?
- Mr. Sangvai: [01:33:26](#) Thank you again for that question. And you appropriately outlined that there are really two different groups of managed care organizations. We have a group that we call the standard health plans, and that's the plan that you might consider to be like your regular insurance company. We also have four tailored plans, and those are managed care organizations that are really designed to take care of individuals who have higher behavioral health needs and other more complex needs. So, we have four standard plans and four tailored plans. Again, eight plans to administer roughly the same book of business. Well, two sets of four to represent comparable sets of books of business.
- [01:34:06](#) On the standard plans, that's primarily in the decision of the agency through a regular procurement process. So, we will send out a bid, interested entities will apply, and then we make a selection. Tailored plans are a little bit more unique. There's a little bit of involvement of the legislature as well in terms of how we structure those primarily since, as you outlined, they've gone through a transition period to be the current universe of tailored plans that we have right now.
- Rep. Reives: [01:34:34](#) Okay. So, at least in that group, the legislature can look at these managed care organizations and say, "Hey, you guys don't seem

to be getting rid of enough of these people, so we're going to reopen the process," or how would that go?

Mr. Sangvai: [01:34:52](#) Intriguingly, there may be ways to put into statute some of the things that you outlined. One of the most powerful tools that we have through the legislature is helping us identify the number of plans we want, because many of the things that we have talked about today really get to the number of plans, and this is where a statute may prevail when it comes to determining how many and any kind of procurement process that we would give an award to.

Rep. Reives: [01:35:18](#) Okay. And now, I appreciate that. Onto Mr. Attorney General. And if I'm hearing you correctly, you're just saying if we fund one position with data mining, you feel like that could make a significant increase in your ability to prosecute. Am I hearing that correctly?

Mr. Jackson: [01:35:38](#) Yes. My expectation is that five years from now, six years from now, 10 years from now, that will be a very robust piece of what we do. We are already the national leader in the space. What I'm saying is, I think we've shown you enough here by internally funding it to make me feel confident coming to you and asking you for that. That is not the game-changer end all, be all, but that is us saying this is clearly the next frontier for generating our own leads in house and just being more aggressive and cracking down on Medicaid provider fraud.

Rep. Reives: [01:36:11](#) Okay. And so, for instance, let's say that we were to award you back some of the many positions. I think we did the 10% or 15% cut to the guy that nobody could remember that preceded you because he won an election. And so, we came back in December and decided he didn't need any staff. And I'm glad they didn't do that to you. And I'm not asking for that to be done to him because he had the nerve to win an election. But if we were, for instance, to restore just that staff we cut from former Attorney General Stein, do you think you'd be able to fund that position out of that staff cut that we, the General Assembly, decided was important to make in December after the election when the state said they wanted Attorney General Stein?

Mr. Jackson: [01:37:02](#) I appreciate the question. Just to answer by way of numbers, we have a \$500,000 annual structural deficit for MID stemming from that cut that was implemented many years ago. So,

remedying just the structural deficit to MID would be 10X the amount that we are asking for.

Rep. Reives: [01:37:25](#) So, I will say, and I'm not going to ask you this question, and if I may be recognized for a statement? Good, I've been recognized. So, if we were serious about this—we restore those cuts, which actually you probably need more now, considering the fact, as they said, that we've had Medicaid expansion since then, more people are on, then if we were serious about it and restored those cuts. At a minimum, that makes your job easier and your ability to do that.

Mr. Jackson: [01:37:55](#) The answer is yes. I'm extremely conscientious to a point that Representative Reeder made fairly that all of you expect people in my shoes to come here and say, in the case of oversight, what we need is more funding. And I'm just trying hard not to do that. The reality, as the leader expressed, is that MID does operate with a \$500,000 structural deficit, and that is despite the fact that we have seen a growth in Medicaid to everyone's point here. However, I'm trying to be realistic about what I think I can ask this body for, which is why I'm asking for one position that I think is particularly high ROI.

Rep. Reives: [01:38:35](#) Thank you. And so, what I would just say in conclusion, I was lucky enough to be able to prosecute for a while. And one of the things that I know that even today I still talk to a lot of the law enforcement officers I work with about is their position was, "If you give me enough resources, I can solve any crime." But obviously every law enforcement organization, if they're underfunded—so, for instance, if you're unfortunate enough to be in North Carolina and be in the bottom 10 of the entire country and the way we pay law enforcement—they have a hard time solving every crime because they can't focus on every single person. And in fact, I mean, for instance, if you had the staff that all of these folks up here have to be able to get people to do Google searches and things of that sort, I would imagine that would be helpful.

[01:39:24](#) And so, I think my position would be what your request is reasonable. It costs nothing. I'm looking at some of our last two budgets that gave \$7 million to Plasma Games, \$20 million to Montreat College over every university we had, \$3.1 million to SolarBees, which you don't want to know what that is, that preceded you. And I think that's the way that we go after any fraud and abuse, but I think cutting resources from organizations and then expecting them to do better, not

dissimilar to what we've done to counties, is hard. And so, I can't speak for everybody, but I would advocate that if we're serious about this, that we provide resources because to this date, we have not been able to legislate more hours in a day. And if you don't have enough staff and you don't have enough resources and you don't have enough systems and software and upgrades, then you're behind folks who may defraud the system. And I think in fairness, as long as there is a system that gives money, there are going to be people trying to figure out how to defraud that. Is that a fair statement to make?

Mr. Jackson: [01:40:41](#)

Yes.

Rep. Reives: [01:40:42](#)

So, I will hope that at the conclusion of all this, that that is what we conclude is that the fact that you are in the top five in the country in most of these statistical categories, with less funding I would bet than most of these other offices, that we try to do things to match funding-wise, what your performance has earned. But I will say, out of everything that I expected here today, because it was interesting-

Rep. Campbell, Chair: [01:41:13](#)

Leader Reives, I'm going to give you about one or two more minutes. We're at 10 minutes.

Rep. Reives: [01:41:16](#)

I can close this in a minute. More posturing than actual work coming from the only body that has not passed the budget in the entire country is probably the best comment I have heard ever in a committee meeting. And I think you have done more work and less posturing, and I appreciate that. But I think that if we're going to be doing hearings and things of that sort, I'd love for us to be spending the effort that we're spending to explain how you could do your job better, even though none of us did it and none of us ran for it. I think we could spend that time trying to close on the budget, which may solve some of these problems by itself. Thank you for being here.

Mr. Jackson: [01:41:55](#)

Thank you.

Rep. Campbell, Chair: [01:41:57](#)

Thank you, Leader Reives. Chair recognizes Representative Warren.

Rep. Warren: [01:42:04](#)

Mr. Attorney General, you're asking for one position. I understand your logic. I agree with you. I support that motion, but our research shows that in the last budget, we gave you 15 positions of which six are still vacant, and we show four financial investigator positions still available. Can you not fill

one of those and allocate or redirect that to that functionality you're asking for?

- Mr. Jackson: [01:42:29](#) That's a very good question, Representative. The slight difference in the situation is that you did give us 15 positions. We have six vacancies total in MID, but those six vacancies are not all within the 15 positions that you gave us. I think within the 15 positions that you gave us, all but two or three have been filled. Our natural... We have fewer than 10% vacancies in MID, which is pretty close to the level of natural churn. The reason why it's particularly difficult for us to hire investigators is because we are doing that at the state salary rate, and frankly, a lot of these people can go work for the FBI. A lot of these people have agencies within North Carolina, within a commutable distance of Raleigh that are just going to offer a higher salary. But as far as being able to keep people and retain them, we're at a pretty good level.
- Rep. Warren: [01:43:25](#) Thank you for that. Mr. Secretary, I have a question for you as well. Can you tell me, can MCOs remove providers for convenience at their own discretionary evolution, or do they need to consult with DHHS?
- Mr. Sangvai: [01:43:40](#) Thank you for that question, Representative Warren. MCOs can remove providers from their network for convenience. Yes.
- Rep. Warren: [01:43:46](#) Thank you. And it's my understanding that the per member per month reimbursement for MCOs is soon going to increase by about 40%, and that represents a pretty significant jump in just a little over the two years since we've expanded Medicaid. It seems like a significant increase in a short period of time. Can you confirm or explain that increase please?
- Mr. Sangvai: [01:44:12](#) Thank you again for that question, Representative. I think you're referring to the 40% increase on the hospital share for the expansion population. I want to make sure that's what your question is referencing.
- Rep. Warren: [01:44:26](#) Well, since it hasn't been announced, and what I'm hearing is hearsay-
- Mr. Sangvai: [01:44:29](#) Sure.
- Rep. Warren: [01:44:30](#) ... I'd just like you to explain what we're talking about.

Mr. Sangvai:

[01:44:31](#)

Sure. Absolutely. Thank you. So, let me take a step back a moment. Remember, when we expanded Medicaid, it was done under the structure that came with the Patient Protection and Affordability Act. What that does is it allows the state to expand Medicaid where 90% of the share is covered by the federal government and 10% would be covered by the state. Just as a point of reference, right now for our non-expansion population, we call that FMAP. Our FMAP is roughly 67%. So, for the non-expansion population, 67% of the cost is covered by the federal government. The money the General Assembly appropriates—that six billion, six and a half billion—makes up the one-third that the federal government doesn't cover. The 40% you're referring to is the 40% increase that's currently forecast for the hospital share for Medicaid expansion. That 10%, that's the obligation of the state, that's actually being paid for by the hospital.

[01:45:34](#)

It's a moment to pause and say, hospitals are now the third-largest funders of Medicaid in the state of North Carolina. We have enjoyed a remarkable relationship working with the hospitals. As a former hospital CEO, I can say unequivocally, the best thing that happened for my hospital was Medicaid expansion. That cost is going up for them by 40%. Their 10% share is going to go up about 40%. At least that's where we are right now. These are the factors that are leading to that. The first is that up until now, we didn't have historical data for our actuaries to use. Now that we have two years of historic data, we can use true North Carolina data to determine what exactly that hospital share is going to look like. Second is, we are seeing costs go up in every single category of healthcare. The three primary drivers of cost—inflation, drugs, certain programs and services—so, that's baked in as well. We have had very productive conversations with the hospitals even as early as this week to try to understand can we reevaluate the actuarial analysis that led to that potential 40% increase. We're also working to understand are there things we can do around drug and program and services that might allow us to decrease that. But I think that 40%... Also, I should mention that most expansion states—the other 40 states that expanded Medicaid—had a similar phenomenon that they started to see around that third year—you see that bump. And I think we even saw that with the Affordable Care Act plans when those went live. So, there should be some stabilizing over time as well, but that's because healthcare costs are increasing. And so, at the same time, while we're trying to figure out how to decrease healthcare expense, we've got to figure out how to get more

value for the dollar and make sure that expense is going exactly where it should go.

- Rep. Warren: [01:47:23](#) All right. Thank you. Thank you very much for that explanation.
- Mr. Sangvai: [01:47:25](#) Thank you.
- Rep. Campbell, Chair: [01:47:27](#) I'm going to make one request for the committee members because, Attorney General, I know you need to try to leave before the conclusion. So, before I recognize the next question, if you have questions that are mainly going to be directed to the attorney general, will you let me know so I can kind of frontload those to respect your time?
- Mr. Sangvai: [01:47:47](#) Thank you.
- Rep. Campbell, Chair: [01:47:47](#) Chair recognizes Representative Echevarria.
- Rep. Echevarria: [01:47:52](#) For a series of questions and a comment. Thank you. Number one, thank you. Your willingness to engage, I am grateful for. This has been amazing. My question is for Secretary Sangvai, so do you want me to wait?
- Rep. Campbell, Chair: [01:48:10](#) No, sir. You can go ahead.
- Rep. Echevarria: [01:48:12](#) Secretary Sangvai, North Carolina made the pioneering decision to fund GLP-1 drugs. And as of January, only 13 out of 50 states have made that decision. So, how did we make what I believe to be the right decision? How did we make the decision, come to the conclusion to fund them?
- Mr. Sangvai: [01:48:33](#) Thank you for that question, sir. Any decision to add a service to North Carolina's Medicaid program first goes through something called the Physician Advisory Group or PAG. And what PAG does, is they evaluate the science, they evaluate the pros and the cons and ultimately make a determination as to whether or not to include something in the benefits of the Medicaid program. What you're, I believe, you're referring to is the inclusion of GLP- 1 drugs, is increasing drugs primarily for obesity. We know these GLP-1 drugs do remarkable things in the treatment of diabetes, cardiovascular disease, sleep apnea, and a few other things. But we also know that they have a profound impact on weight loss. And so, the decision North Carolina made was, can you look at the impact that weight loss can have on other expenditures related to healthcare? So, we

know that type two diabetes' number one leading cause [of improvement] is weight loss.

[01:49:32](#)

So, if someone loses weight, does their need for treatment of diabetes decrease? Similarly, there are cardiovascular benefits and so forth. There is a ton of data out there on whether or not GLP-1s, specifically for the purposes of treating obesity, can actually lower healthcare costs. You can find one study that says it does; you'll find another study says it doesn't. As more and more indications come out, that's actually making it a little bit more complicated. So, I would say North Carolina's experiential data as to whether or not it decreases costs downstream is TBD. Here's the one thing that hasn't been considered: As we think about helping North Carolina's healthcare crises, or challenges rather, particularly in rural areas, economic development is going to be a key component of that. And if you step outside and look at what employers are considering with GLP-1 drugs—as you know, they're considering whether or not we keep it for the same reasons. Again, for the obesity purpose.

[01:50:33](#)

They're looking at endpoints as to whether or not you can keep employees employed. They're looking at work and productivity. You can imagine that if you had a workforce that was compromised by health reasons related to shortness of breath because of obesity, problems ambulating because of obesity, you bring the bonuses of those costs in the analysis, and you have a different picture that's going to likely lean towards there is value in investing in those. So, I think our GLP decision is a TBD decision. By the way, we get a remarkable discount, and the cost is exceedingly low. And we all know that the federal government is looking at ways to decrease the cost of these, but the final calculus must not only include the healthcare costs but the added benefits that our state receives.

[01:51:23](#)

And that's not just for GLP-1 drugs. We do that for everyone. This one has just come up because there is this ability for us to kind of examine it more in a public domain—but the number one drug that is... The number one cost drug in Medicaid is not GLP-1 drugs. It's actually Dupixent. It's a drug that's used for atopic dermatitis. And so, we apply that same standard for anything that's included in our drug benefit. So, I appreciate the question. I also appreciate the opportunity for us to start leaning towards a more definitive answer as to whether or not we actually get ROI on GLP-1 drugs for obesity.

Rep. Echevarria: [01:51:59](#) Excellent. Thank you. To follow up to that, I mean, your predecessor estimated that it would be a \$16 million cost. Obviously, the actual costs went up to exceed \$270 million. Now we've got some of that under control, as you mentioned, but my question for you is this: Going forward, what are you putting in place to make sure, or how are you changing things to make sure that we don't see that kind of discrepancy or underestimate?

Mr. Sangvai: [01:52:26](#) Thank you for that question. One of the hallmarks of our Medicaid program is our drug benefit. Our team does a remarkable job of procuring drugs at the lowest cost possible, capitalizing on any rebate, instituting step therapy so individuals don't use the most expensive drug first, ensuring that there's pre-certification for those high-cost drugs, and so forth. What we are able to do in that setting is to ensure that if an individual is prescribed any drug, including GLP-1 drugs for obesity, are they taking it on a regular basis? Is it being refilled? Are you getting the type of weight loss that you would expect to get?

[01:53:05](#) The science is changing simultaneously as well, and we'd want to include that science in there. There's science now that's suggesting that you might not need to take as much to get the same benefit. So, this is where I think the North Carolina program is a superstar because we bring that science into making these decisions. We run the decision through everyone who has the clinical competence and the understanding to be able to do it and routinely check whether or not it makes a difference.

Rep. Echevarria: [01:53:32](#) Excellent. Thank you. And my comment is this: this has been one of my, maybe my favorite oversight meeting because it's been so informative, very direct. And I have to tell you that there was something said—obviously we need a budget, and all of that is known. However, national issues have brought us into this committee meeting, things like... I mean, Epstein was arrested in 2019. We had years of silence, and now we're demanding justice. We have Learning Center in \$19 billion worth of fraud allegedly in Minnesota. And I mean, if we bring it home, we still haven't reconciled our Hurricane Matthew recovery and how that spending went.

[01:54:19](#) I don't think... Well, I'm pretty certain none of my neighbors or friends believe that we're big-game hunting at all. It actually feels like we've created an environment where we punch down on people who don't have the resources to protect themselves

or defend themselves. And those who have the resources have the free-for-all to be Epstein, to commit \$19 billion in fraud, or even commit immigration fraud like allegedly Congressman Omar has. And so, Attorney General Jackson, I could tell you, one, I am rooting for you. You're still shaping your agency, and I think we're all depending on you to do the big-game hunting that all of us as North Carolinians are looking for. So, I thank you for being here, and I look forward to you getting results. Thank you.

- Mr. Jackson: [01:55:13](#) Thank you.
- Rep. Campbell, Chair: [01:55:14](#) I'm going to go a little bit out of order in respect to your time, Mr. Attorney General, and I'm going to recognize Representative Chesser again for a series of questions.
- Rep. Chesser: [01:55:25](#) Thank you, Mr. Chair. I had a line of questioning that I was going to direct at both of you. So, with respect to the chair, I'll skip to the parts that mainly I wanted to talk to the Attorney General about, and if time allows, I'll come back to you. Thank you. Wouldn't be fair if I didn't give you a chance to take a victory lap, right? So, your office has done pretty good work in the area of behavioral health. You've had some pretty good victories in that area. Would you like to talk about them with the Shabazz case, the Washington case? Anything in that vein? Because I think you could talk about those. They're both closed out, and you got convictions on those.
- Mr. Jackson: [01:56:08](#) These are cases in which, if I recall, I believe in particular the Shabazz case involved a major case of phantom billing and someone obtaining PII from a list that we were able to crack down on.
- Rep. Chesser: [01:56:25](#) That's not much of a victory lap.
- Rep. Dahle: [01:56:29](#) AG Jackson does not take victory laps. He does his job. That's what he does.
- Rep. Chesser: [01:56:34](#) So, you want to talk about what that organization was and what they were phantom billing for?
- Mr. Jackson: [01:56:42](#) Well, in the vast majority of these cases, they're phantom billing on behalf of patients that don't exist. So, in [a range of] particular services, behavioral health [and] often involve substance abuse treatment. The Sims case that I referenced a

few times that was closed last month was a substance abuse case.

Rep. Chesser: [01:57:03](#) Okay. In testimony that was provided, we'll just skip ahead. We've seen that ABA therapy is growing about 350% over the past several years or few years. The federal government has flagged that as high propensity for fraud.

Mr. Jackson: [01:57:23](#) Yes.

Rep. Chesser: [01:57:24](#) What proactive steps—to both of you—but obviously in respect for your time, Mr. AG, what proactive steps are you guys taking to address this well-documented concern?

Mr. Jackson: [01:57:35](#) Completely agree and appreciate the fact that this was raised before I left so I had a chance to speak to it, because you are right. If you look at the growth in the expenditure for ABA therapy, it deserves to be flagged as a potential source of fraud. The idea being, and we all agree with this, people who legitimately deserve those services, which is all the more reason to go after people committing fraud and draining those resources. So, that being said, here's what we're doing: First, I've asked us to spotlight this because I anticipate that we are going to have fraud in this area. You can't have growth of this magnitude and not.

[01:58:15](#) Second, we've made some programmatic recommendations to some of our partners to make these cases easier to prosecute. This is in my written testimony. There are a number of programmatic recommendations that we've made. One of those specifically applies to this. In short, the wording around what some of the requirements are for offering ABA therapy is a little too vague and would make that case a little too difficult to prosecute. So, we've spoken with DHHS, and they are very open to addressing this. Last, and this is not something I can go into detail about for obvious reasons, there are ongoing investigations into this right now.

Rep. Chesser: [01:58:57](#) With respect for how long you've been in office, have you had any settlements or convictions in the ABA area?

Mr. Jackson: [01:59:05](#) I would have to look to see. We've had several dozen. I would have to look to see.

Rep. Chesser: [01:59:10](#) Okay. Can you provide that to...

Mr. Jackson: [01:59:12](#) I'm happy to.

Rep. Chesser: [01:59:13](#) ... to us, because cursory research, I couldn't find any.

Mr. Jackson: [01:59:16](#) Understood.

Rep. Chesser: [01:59:17](#) I guess that comes in lieu of your statement that it's difficult to prosecute.

Mr. Jackson: [01:59:23](#) Well, all of these cases involve significant investigation that isn't going to get turned around within six months. But to your point, given the growth that we have seen there and given current investigations, I think you raise a fair issue. There is a genuine reason to flag this.

Rep. Chesser: [01:59:40](#) And is the primary thing that you guys are seeing improper payments, phantom billing? What is...

Mr. Jackson: [01:59:48](#) Representative, I want to be fully candid with you, but I also just need to be cognizant of some ongoing investigations.

Rep. Chesser: [01:59:53](#) I'm just asking in generalities.

Mr. Jackson: [01:59:57](#) The issue is that's not in generalities. That's actually relatively specific. I guess if I could answer with a generality, it would be both. At least to some extent. Just not trying to tip off any of the bad guys here, Representative.

Rep. Chesser: [02:00:14](#) I've been part of investigations as well, and so, I've been prone to work with law enforcement to track down and put away sex offenders and child traffickers.

Mr. Jackson: [02:00:29](#) No, I completely agree.

Rep. Chesser: [02:00:29](#) And I can say in generalities that we use online platforms to hunt them. I may not tell you what they are. So, I understand when I'm asking a question that's in a general nature and when I'm not.

Mr. Jackson: [02:00:40](#) You're absolutely right about that. The difference with respect to that case and these cases is our adversaries here are just extremely well-funded. They have major law firms, and they can mount a level of defense that is just orders of magnitude more sophisticated. And I try to be very conscious of that when I'm making public remarks.

Rep. Chesser: [02:00:59](#) I agree. But if we're narrowing down what you're looking for when you're looking for these things, if those bad actors then stop phantom billing, I think that's a net gain to the state.

Mr. Jackson: [02:01:12](#) Agreed.

Rep. Chesser: [02:01:14](#) If they stop having ghost clients—clients that don't exist, that's a benefit to the state.

Mr. Jackson: [02:01:21](#) Absolutely.

Rep. Chesser: [02:01:22](#) So, I don't think that jeopardizes your investigation. I think that's a direct benefit to the state.

Mr. Jackson: [02:01:26](#) You're correct. I just meant I'm a little careful about getting into specifics about certain trends that we're seeing at the moment.

Rep. Chesser: [02:01:33](#) In general, with this being potentially the largest area for fraud that is in our current budget or expenditure cycle, where can we go to track the progress for both of your offices if this is being proactive? Because you've made recommendations of how to make it a priority, but up to this point, those recommendations have not been adopted. And Dr. Sangvai, your office, reviewing kind of where your priorities are, your priority service matrix for fiscal year '24 and '25 makes no mention of ABA therapy. So, where can we go as legislators and where can the public go to hold you guys accountable to your pledge?

Mr. Jackson: [02:02:24](#) We will share those numbers with you with respect to investigations, referrals, things of that nature.

Mr. Sangvai: [02:02:30](#) And similarly, I'm happy to talk more about our approach to ABA. The tool that's most immediately available to us is changing our clinical coverage policy, which is going to include—and we are bringing forth recommendations—22 recommended changes to our clinical coverage policy to go live as early as August 1. Included in there will be requirements for supervision, the limited use for telehealth, and some of the other things that we think may have been contributing to the numbers that we've seen that have been skyrocketing in the ABA space. And so, we'll be able to see that directly out of claims.

[02:03:06](#) I'm sorry, sir. The one piece we'll have to put a process in place is that there's a supervision model in the delivery of ABA care, and we're going to put a cap or a floor requirement on that supervision. That will be difficult to capture out a claim. So,

we're going to have to put a system in place to make sure that if there is a board-certified behavioral analyst, they're only supervising the number of people that they can legitimately supervise by giving them the floor recommended amount of supervision time.

- Rep. Chesser: [02:03:36](#) And just to either one of you that want to take it—when a referral's made for a complaint, you can follow that investigation wherever it goes, correct? Whether ...
- Mr. Jackson: [02:03:48](#) Yes.
- Rep. Chesser: [02:03:49](#) ... it leads to civil, whether it leads criminal, it's your baby until you hand it off for prosecution is my question?
- Mr. Jackson: [02:03:57](#) I think the general answer is yes. However, there's a narrow band of cases in which once referred to us by one of our partners, we make another referral to another agency because they have administrative tools. If the evidence does not prove civil or criminal fraud but still warrants administrative action like turning off-
- Rep. Chesser: [02:04:15](#) What if it's not fraud at all? What if it's just regular criminal activity like neglect or abuse?
- Mr. Jackson: [02:04:19](#) Then that's an excellent question because the two things that we're really charged with at MID is going after Medicaid provider fraud and patient abuse. However, as I told you with Medicaid investigations, we call the DA. When we have evidence of criminal conduct and that DA gives us the case, which is what we have to do under state law; different for patient abuse. We call the DA, and we say we have evidence of patient abuse, they're much more likely to take it. And frankly, they're more likely to find out before we are, because most of the tips for patient abuse come from locals, which go then to local law enforcement, which then go to the DA.
- Rep. Chesser: [02:04:57](#) Okay. Just a brief follow-up on that, if you'll allow me, Mr. Chair. Looking through the files, looking through the data, we have found several providers that have gone through the investigative process and been found for abuse, neglect. And we're talking about children. I focused mainly on foster care and child protective services and child safety, child welfare. Several providers have been, for lack of a better term, prosecuted, held accountable by your agency. Yet they still retain their ability to charge Medicaid for services. They still maintain licensures.

What does it take to get kicked off the Medicaid roles? Because obviously you just pay a fine if you tie a child up with zip ties. You just pay a fine if you sexually assault a 16-year-old. You just pay a fine if you sexually touch a six-year-old. You pay a fine if it's confirmed that there was serious abuse and harm and neglect. What does it actually take for our state to say you are no longer eligible to service these patients?

Mr. Sangvai: [02:06:06](#) So, in those horrific examples that you've given, those providers would be suspended. When the Medicaid agencies are made aware of that criminal activity, those providers would be suspended. In my earlier comments, I wanted to make a clarification between somebody still being in the Medicaid network and being able to bill for Medicaid. The next step would be to summarily remove them from the Medicaid network. But as far as being able to continue to render services, their ability to render services would be stopped, for lack of better term, because of that status.

Rep. Chesser: [02:06:40](#) At what point? Not to belabor the point. There are multiple agencies or organizations that we can point to. One of the most egregious—the first complaint was substantiated in 2018. They had another complaint, several complaints, maybe 15, if I'm counting correctly, in 2024. These are all egregious complaints that are substantiated, but there's almost two a year while they're going on. At what point do we say enough is enough? You have the authority—you've said it several times. You say the MCOs and LME/MCOs have the authority to remove them. Why is this occurring?

Mr. Sangvai: [02:07:20](#) Representative Chesser, I look forward to the opportunity to work with you to figure out how we can close that gap. We never want an unsafe provider to be providing services in the Medicaid network.

Rep. Chesser: [02:07:32](#) So stop paying them.

Mr. Sangvai: [02:07:33](#) And in these cases, they are stopped from being paid, but we have to find a way, like you said, to just take them out of the system altogether. There have been situations where we have done that in the past, and individuals have looked to appeal rights and that sort of stuff, but that should not inhibit us from saying there has to be a threshold level at which point you're out and you're out for good.

Rep. Chesser: [02:07:57](#) No further questions Mr. Chairman.

- Rep. Campbell, Chair: [02:07:59](#) Thank you. And last one out of order, I'm going to go to Representative Cervania.
- Rep. Cervania: [02:08:06](#) Thank you, Chair. Series of questions for our guests here.
- Rep. Campbell, Chair: [02:08:14](#) You're recognized.
- Rep. Cervania: [02:08:14](#) I'm recognized?
- Rep. Campbell, Chair: [02:08:15](#) Yes.
- Rep. Cervania: [02:08:15](#) Thank you very much. All right. Thank you so much, Secretary Sangvai, Attorney General Jackson. I know you're limited on time. I'm going to address my first questions towards you, but I do want to preface this by saying, I have worked at a state Medicaid office. I've been on a board of LME/MCOs. This is part of my profession, and I don't dare to say I'm an expert on any of this, and I am privileged to be able to be working in this space. I need to remind my colleagues we're a committee of oversight and reform. And in that responsibility, we need to be very careful about the questions that we ask and the directions that we're trying to convey when it comes to the public who's listening right now and how we further make decisions in hope and partnership with both of you when it comes to resolving Medicaid fraud in North Carolina.
- [02:09:18](#) I do want to say that we all agree that there should be prosecutions, and they should be aggressive. We've seen in your testimony that that is also your commitment too, but I want to reiterate that these need to be verified and substantiated evidence-based decisions of fraud. Attorney General Jackson, a series of questions here have been asked, why does your office—your department—have so many calls of fraud and why have they been lessened and lessened when it comes to actual results. But what I know, and please correct me, your department investigates every investigation that's called in from every source. Possibly the reason why, and probably the reason why it lowers in number when it comes to fruition, is that they're not substantiated by the aggressive and well-pursued investigations of your department. Is this true?
- Mr. Jackson: [02:10:38](#) I appreciate that question. I think that's an accurate assessment. These decisions are made by prosecutors in this section. These are prosecutors who do one thing, and it is this: If we have cases in which we feel the evidence will support a conviction, then we're going to take it to trial. If we don't, then

we're going to refer it back often to get more evidence, to give the recommending agency sort of a second bite at the apple at helping us with the investigation.

Rep. Cervania: [02:11:07](#) And there's a high percentage that actually could be calls for investigation that can't be further investigated because there's no... It might not even be, I can't say, a real call for fraud, but that could be possible too, correct?

Mr. Jackson: [02:11:26](#) Yes, that can be possible too.

Rep. Cervania: [02:11:28](#) Also, I want to really clarify—and you've alluded to it too—we know in the space that Eddie Kirby is one of the most renowned people when it comes to MID, and we need to be very clear that experts need to be the ones to be able to set the pace, set the direction of the future of this. Because if we don't make it clear to our people and us who fund departments and help support agencies like yours, that if we don't put it in the hands of experts, we would be actually doing a detriment to our people in North Carolina. So, I hope my colleagues here remember that. We have the most renowned person working for you, Attorney General, and we need to be able to support that, be it when it comes to funding, which you all are being very careful of asking for.

Rep. Campbell, Chair: [02:12:35](#) Representative Cervania, if you could suspend for a minute, I bumped you up because you said you had a question for the Attorney General.

Rep. Cervania: [02:12:40](#) Yes.

Rep. Campbell, Chair: [02:12:40](#) Do you have a question for the Attorney General.

Rep. Cervania: [02:12:43](#) Yes. So, I'll just ask one last question. In the light of the challenges that we provide to you in terms of questioning your agency, but also just the reality of needing to really address Medicaid fraud, what can you ask from us to help in partnership with you to be able to make sure we address Medicaid fraud in the best way possible for your agency?

Mr. Jackson: [02:13:09](#) I appreciate that question. I've made a couple of tangible asks to all of you. I appreciate your consideration. Beyond that, we welcome the oversight. I think this is really healthy. I brought my son—he's in fifth grade—because he's learning about checks and balances, and I told him about this, and he asked if he could come. We are not only in the business of delivering

accountability, we are in the business of subjecting ourselves to it. And frankly, the process of preparing for this hearing was very helpful for me. I appreciate the opportunity. Thank you.

Rep. Cervania: [02:13:44](#) Thank you. I will yield ... Chair after ... I'd like to yield my time now, but still have the rest of my time being able to ask Secretary Sangvai his questions after the departure.

Rep. Campbell, Chair: [02:13:59](#) Certainly. Thank you.

Rep. Cervania: [02:14:00](#) Thank you.

Rep. Campbell, Chair: [02:14:01](#) Chair recognizes Representative Cunningham.

Rep. Cunningham: [02:14:05](#) Thank you, Mr. Chair. And thank you both for being here. I have some questions for you, Attorney General, and some for you, Secretary. Attorney General, the penalties don't seem to be enough to deter people from doing Medicaid fraud and waste. If we had to look at that you've got civil, you've got criminal, what could we do at the state level to add a deterrence to individuals doing Medicaid fraud and waste?

Mr. Jackson: [02:14:38](#) Representative, you're exactly right to think in terms of deterrence. Incidentally, there was a study that came out about 18 months ago that showed for every dollar we can report having been obtained by criminal or civil forfeiture, it has a deterrent effect of roughly \$10. There is some, and that's highly speculative, but the point is simply, there is a measurable deterrent effect in our ability to show people that there are regular consequences for this. Deterrence is fantastic. I mean, ideally, we can deter a lot of this crime because people will know that if they commit fraud, they're going to prison.

[02:15:16](#) Now, specifically to answer your question earlier—I think it was with Representative Campbell—I think I was talking about why so many of our cases go federal. The reason being, there are real penalties under federal law for this. And frankly, under state law, there are not. I'm not sure the rationale for that, but I talked to my team about it, and they weren't sure either. And if they don't know, and to your point, Representative, they're the national leaders, that tells me there probably is not a good reason. I think we have just become reliant on our federal partners who are great, but it's time to take more of these cases stateside, which also may help us move them quickly. We love the federal courts. We're grateful for them, but they ain't quick. We'd love to handle more of these cases in state court.

- Rep. Cunningham: [02:16:00](#) Okay. My second question: is there a database that has the list of the entities that have already violated or that have already committed fraud—an internal list that even the Department of Health and Human Services has access to—you all have access to it and other entities that are in the same space of watching for fraud?
- Mr. Jackson: [02:16:24](#) I believe the answer is yes, Representative Cunningham. I think the keeper of the list of people who have had sanctions other than civil and criminal is probably DHHS. I think there's been some conversation already about the administrative leeway they have in dealing with people on that list, but the most comprehensive bad-guy list, I imagine, is probably with NC DHHS.
- Rep. Cunningham: [02:16:47](#) Mr. Secretary?
- Mr. Sangvai: [02:16:49](#) We do have a list of providers who have been sanctioned or have been removed from networks. It's important to remember that there are about 100,000 providers in the Medicaid network more broadly. Every year, around 16- to 19,000 fall off of that. Now, that's not all for fraud, waste, and abuse. Some of it is voluntarily withdrawing, but these are not individuals who fall out because they are simply not re-enrolling. So, we have a way of identifying individuals who are on the list and those who fall off.
- Rep. Cunningham: [02:17:26](#) Okay. Mr. Secretary, so, once they are identified, either at the LME or the MCO level or at your level, are they placed on the list and cannot get a contract forever, or is there another option that they can come back under another entity and get a contract—a third-party contract with the LME/MCOs?
- Mr. Sangvai: [02:17:53](#) Thank you for that question, Representative Cunningham. If there is a provider who's on the list, it's important to understand why they are on the list. So, for example, if it's because of lack of timely filing of claims and they need to understand that you need to file a claim in a certain amount of time in order to get paid, and because you haven't for some time, we are now going to put you on the list. If the provider then is able to perhaps get an electronic health record that helps filing claims in a timely fashion, then they would be able to be recertified and reenter into the Medicaid network. So, it specifically depends on what's put them on the list, for lack of better description.

- Rep. Cunningham: [02:18:32](#) Follow up. So, I'm specifically focused on the fraud and the waste. When we were in Health and Human Services Oversight, one of the things that we brought up is the continuation of the individuals, providers, whoever, to continue to be paid while under investigation. And it seems like it takes a long time for you all to get to a resolution before you stop paying. And you say that it's not good for the client or the patient who's receiving the services to stop paying like that. What do we have as an available tool once they're identified that we don't have to keep on holding off before we can take final action on the provider, whoever it is?
- Mr. Sangvai: [02:19:20](#) Sure. Thank you again for that question. If a provider is under investigation and there is value in continuing to generate evidence by having them continue to submit claims, that provider can still be put under prepayment review. So, even though they're actively billing, each one of their claims can be reviewed. And if that claim is legitimate, because some of the bad actors may be submitting legitimate claims, and if their claim is not legitimate, then the non-legit claim does not need to be paid, but the legit claimant. So, it allows them to stay in the business generating the evidence without necessarily encumbering more financial loss on the part of the state because they are getting paid for claims which they otherwise should not get paid.
- Rep. Cunningham: [02:20:06](#) Okay. So, the LME and the MCO follow up under the prepay, but the Department of Health and Human Services does as well.
- Mr. Sangvai: [02:20:14](#) Under the prepaid plans?
- Rep. Cunningham: [02:20:16](#) Yes.
- Mr. Sangvai: [02:20:16](#) So, the prepaid plans apply to those four PHPs, those standard plans, and the four LMEs. You're exactly right. The agency runs its own Medicaid program called Medicaid Direct, and that is not a prepayment plan. That is a traditional fee for service plan.
- Rep. Cunningham: [02:20:38](#) Thank you.
- Rep. Campbell, Chair: [02:20:40](#) Thank you, Representative Cunningham. Chair recognizes Representative Willingham.
- Rep. Willingham: [02:20:45](#) Thank you, Mr. Chair. Most of my questions have actually been answered, but I do have a couple for the Secretary. My district is a rural district, and we're in what I consider a kind of a medical

desert. So, I would like to know what is it that DHHS is doing or can do to assist rural areas like mine who are in a healthcare desert in the sense that there is no hospital or very few healthcare services or providers. Is there anything ... Can you tell me what you're doing or what you can do to assist in that area?

Mr. Sangvai:

[02:21:33](#)

Thank you for that question, Representative. I mentioned earlier that I was a hospital CEO, and it was in a large metropolitan area. And I can say that our ability to deliver the services that we were providing was fully contingent on every surrounding rural hospital not just surviving but thriving. And that has informed the approach at the agency since I was lucky enough to be in this position. There are a number of things that we're doing to support rural communities. Some of it's on the workforce side. Some of it's also on the infrastructure side. But I think the most important piece moving forward is something called the Rural Health Transformation Project. This is a federally funded project that's designed to work with rural communities to understand what their most pressing immediate needs are to help create a sustainable healthcare model in those rural settings.

[02:22:27](#)

I don't envy the work you have, sir. It is incredibly difficult to get providers to go into rural communities. Our rural hospitals are struggling, not only by having payer-mix challenges but also some infrastructure challenges, whether it's related to deferred maintenance or any of the other things that we need to do. Urban healthcare in North Carolina cannot thrive unless rural healthcare thrives. There is no model where the urban centers can accommodate the need of those rural centers. So, this is not a rural North Carolina problem, this is a North Carolina problem. And I'm happy that we have over \$200 million from the federal government that's going to help support us down this pathway but also things that we're doing specifically from the agency to help encourage individuals to support and create a rural workforce.

Rep. Willingham:

[02:23:13](#)

Just a follow-up. To be direct, Martin County is in my district, and the hospital there has closed. So, we don't have a hospital, and we have very little medical services. So, I'm asking, I guess, with the situation now as it relates to Medicaid—the effect on that—because I think at some point there was some money that was supposed to be coming to those rural hospitals from the feds through the state, and now there seems to be a problem. So, can you bring me up-to-date on that?

Mr. Sangvai: [02:23:55](#) I appreciate that, sir. I should have done the math and recognized that Martin County General Hospital was in your district. I had an opportunity to visit the facility about two to three months ago and was profoundly impressed by the people who are so proud of that facility. I mean, it has a lot of things. It's got good bones. It's got good structure. The community needs it, but there's a group of people—the only word I can think about is love. They have love for that place, and they want to see that place thrive. As we talk about Medicaid, rural communities are going to need Medicaid and a strong sustainable Medicaid program in order for those rural communities or hospitals to otherwise survive. There was some confusion when House Resolution 1 was passed and this Rural Health Transformation Fund was identified as dollars available to help rural communities.

[02:24:45](#) In the early part of summer, there was some thought that those dollars could be used for infrastructure, could be used for capital improvements, and so forth. So, I think it makes sense that places like Martin County were thinking, "Hey, could this be used to help some of the needs for the community?" Those funds are now restricted for very specific programmatic things, and I'm happy to find some time to meet with you and your office to share how we have outlined how North Carolina intends to spend the funds.

[02:25:12](#) That being said, I'm excited to continue to work with partners at ECU and Martin County to think about how you make places like that areas where we actually totally thrive rural-based healthcare. How do we not only just look at it from a hospital perspective, but how do you create a primary care base there? How to do all the other things that we need there? But I'll go back to what I said earlier. Martin County is just an example of if we don't figure out how to solve challenges like that, it's only going to exacerbate the problem.

Rep. Willingham: [02:25:43](#) One final thing—I'm just curious—with the money that we're getting from the feds, it's my understanding, and I don't know this as a fact, that most of that money would be going to the UNC Hospital and one of the other large hospitals. And as I remember, or I was told, that some of that money was supposed to have been coming to Martin County. So, I'm just curious, what happened to divert that money from coming to our county and going to this area, the UNC systems, which certainly doesn't need the money as much as we need it in our county.

- Mr. Sangvai: [02:26:30](#) Sure. Sir, if you're referring to the Rural Health Transformation money, I suspect people are giving you misinformation. Not a single dollar from Rural Health Transformation money has been appropriated to any entity to this point. So, if anyone is claiming that they have RHTP dollars, they are not stating the truth. The way the dollars are intended to be distributed is to be in an equitable fashion, to make sure that all rural communities in North Carolina have an equal opportunity to be able to find pathways to sustainability out of those funds, but no specific entity has been named as a recipient of not even one dollar to date.
- Rep. Willingham: [02:27:07](#) Okay. Thank you.
- Mr. Sangvai: [02:27:09](#) Thank you.
- Rep. Willingham: [02:27:09](#) Appreciate that. And I would like to get with you on that.
- Mr. Sangvai: [02:27:11](#) Absolutely.
- Rep. Campbell, Chair: [02:27:13](#) Thank you. I do not have anyone else to me that says they have a question for you, Mr. Attorney General. I know you have to stop. Oh, okay. Let me ... Representative Quick, you're recognized.
- Rep. Quick: [02:27:25](#) Thank you very much. And I'll let you get out of here as quickly as possible. When we talked about Medicaid expansion earlier, we talked about covering the number of people and how in expanding the coverage, there seemed to be some level of fraud that came with expansion. I want to talk specifically about autism service providers, as this seems to be a target—I don't know if target is the right word—a concern of this General Assembly, particularly the majority. First of all, speak to that in general—the expansion of autism service providers in the state of North Carolina. Is that a reflection of the incidence or the number of diagnoses going up that we're seeing—this explosion—based on what you know? And is there any concerning trend about fraud in autism service providers in North Carolina?
- Mr. Jackson: [02:28:20](#) The answer to the first question I think is probably better handled by the Secretary, honestly, as to the cause and how that cause lined up with expansion. The second question though about, is there a fair anticipation of fraud given the expansion of utilization that we have seen. The reason why I think there is a fair expectation of fraud is that there is now a major incentive

for it. And it's my job as law enforcement to be suspicious of any area where there is a financial incentive to commit fraud.

- Rep. Quick: [02:28:59](#) Follow-up to you: what safeguards and guardrails have you learned from your investigations of previous Medicaid fraud that can mitigate some of the fraud that you anticipate?
- Mr. Jackson: [02:29:10](#) That is an excellent question. And the answer is, there is some specific wording for billing requirements that is ambiguous and needs to be tightened up that can provide some wiggle room to some fraudsters as a legal defense, where we can prove that they were clearly up to no good, but they would have an argument in court against us because of a couple of phrases that are too ambiguous. We've had that conversation with NC DHHS. They've been very receptive. As the Secretary said 10 minutes ago, they're planning on introducing over, I think you said, 20 changes in this area. A lot of those changes are to help tighten up language, to help making the case for us easier.
- Rep. Quick: [02:29:56](#) And that's all the questions I have for the Attorney General.
- Rep. Campbell, Chair: [02:30:00](#) Mr. Attorney General, I know you have to go and we really appreciate you being here. We appreciate your son's patience as well. If you need to step away, we certainly appreciate you being here today.
- Mr. Jackson: [02:30:09](#) I appreciate the conversation. And to the 67 folks at MID who are watching right now: you are public servants. I'm grateful for you, and I'm proud of you. And thank you so much.
- Rep. Campbell, Chair: [02:30:23](#) Thank you, Mr. Attorney General.
- [02:30:24](#) Representative Quick, do you have other questions though for your time?
- Rep. Quick: [02:30:28](#) I do.
- Rep. Campbell, Chair: [02:30:28](#) Okay. Please proceed.
- Rep. Quick: [02:30:29](#) Thank you, Mr. Chair.
- [02:30:30](#) To the secretary, again, thank you for being here as well. Again, staying focused on autism service providers. Of course, the state is going to have to spend more money on providing services for this population and their families. Is there a trend? Is there some forecasting that you can do as to what would be a

reasonable amount that the state could anticipate spending to provide these services as the number of diagnoses increases?

Mr. Sangvai:

[02:31:00](#)

Yeah. Thank you, Representative Quick. I want to go back to how we got here in the first place because that's going to help us understand how we get out of here, and there were a number of things that happened. I think it stands to say that, for a large time, the autism community was ignored, and it was considered to be something that wasn't medical, for lack of better term, and so credit to all of society for recognizing that ASD is a legitimate issue that many families deal with. Simultaneously, a science was developing on how you help individuals who are part of the ASD community to deal with all the challenges that they have. A third thing occurred where the experts who provide this kind of care, called behavioral health analysts, developed a board certification process, which also tightened the credentials and the proof, if you will, that you need that this is an individual who can provide this type of care.

[02:31:53](#)

All this time, you have this pent-up demand. You have kids who are not getting that type of care. So, you create a well-intended scenario where you have individuals who can now get this care. You're providing services to those who really need it, providing an opportunity for individuals who are providing this care to be reimbursed at a reasonable amount as well. What ended up happening during that time period—and we see this throughout the country, which is why about a year ago we released the white paper to really get the feedback from the entire ABA community to understand what's happening in North Carolina is exactly those things that the attorney general was referencing to—gaps and opportunities for exploiting the models that people had put into place, and those are the things that we need to close up. A couple of things that we're looking at among the 20 changes we want to make to clinical coverage policies: the role of out-of-state providers in North Carolina.

[02:32:51](#)

If you look at the number of out-of-state providers, it's pretty high. Now, one might say, "Well, why do you even have out-of-state providers?" Well, we knew we had this pent-up demand. It was at a time when telehealth was expanding as a way to deliver healthcare, but we now know we need to rein that back. That's one of the many things that we're contemplating in putting forward in the change of the clinical coverage policy to make sure that utilization of those services is really going to those kids who need it most. We think, over time, what we're going to be able to see is more optimal utilization. And when

you have more optimal utilization, it means you're going to have less utilization. Less utilization should lower the expenditure on ABA.

Rep. Quick: [02:33:33](#)

Thank you very much. Thank you, Mr. Chair.

Rep. Campbell, Chair: [02:33:36](#)

Clarifying question, Mr. Secretary, in terms of when your department testified in March about the growth of ABA, we talked about the previous lack of services, growth in diagnostics. Your department testified at that committee that your factors that you put forward for ABA expansion did not account for the totality of the growth and that there was a good portion of the growth that you had no explanation for why. Are you changing your testimony now, or is that still a problem?

Mr. Sangvai: [02:34:16](#)

That still persists. Thank you for that opportunity to clarify, Dr. Campbell. The ability to bill under telehealth was a blind spot for the agency. The codes that were being submitted as truly telehealth codes but not actually being... I'm sorry, let me rephrase that. There were codes that were being submitted but were being submitted through the provision of telehealth services. So, they look like legitimate face-to-face services, but they were, in fact, for telehealth. And that's the gap that we intend to close—that telehealth services will be limited in scope, duration as well as the circumstances under which they'd be delivered. We want to make sure that, for example, rural communities are not compromised by overtightening the telehealth. But we also want to be clear that if the provider is in Wake County and the patient is in Wake County, you have to have a good reason for telehealth services, for example.

Rep. Campbell, Chair: [02:35:13](#)

Thank you, Mr. Secretary.

[02:35:14](#)

Chair recognizes Representative Hawkins.

Rep. Hawkins: [02:35:18](#)

Thank you, Mr. Chairman. Thank you, Mr. Secretary. Really appreciate this full discussion. This has ended up being one of my more favorite oversight meetings, mainly because of the topic, or the topic that we eventually sort of got to, which concerns those with autism spectrum disorder. I have two sons with autism and am the co-chair of the IDD Caucus, and so that's why a lot of just listening has been happening and a lot of good questions. To add on to Dr. Campbell's question about the growth—one piece of information that I think, for historical purposes, is that North Carolina also intervened because of the pent up demand and passed the bill that allowed for a structural

board to be put in place so that we could appropriately expand ABA in North Carolina. That is important context for those who have not been a part of that discussion or... It doesn't necessarily explain away all the growth, but it definitely says that North Carolina gave the signal that we were ABA-friendly.

[02:36:20](#)

For those who were in the autism community, they took that signal as we are now open for business and that we need to be diagnosed at higher rates, actually stepping out of the shadows to get care, but also to make sure that they were getting the care that they deserve. So, only question of- you mentioned making sure that rural communities are not hurt by the structural changes that need to be made—what are you seeing... Because one of the things that was helpful about putting forth that bill—because I was a part of some of that—was that we realized that if you were in urban centers, you were okay, but if you were in rural communities, you were not. Are you seeing an explosion in rural communities? What's the difference between the rural and urban divide for these services?

Mr. Sangvai:

[02:37:09](#)

Thank you for that question, Representative Hawkins. I can't speak with confidence on what we see specifically with respect to rural and urban and patients who may benefit from ABA therapy. But if we were to extrapolate what we typically see in rural communities versus urban communities, we see underdiagnosis, undiagnosis, and delay in diagnosis, and all three of those can lead to poor clinical outcomes as well as increased costs. If we have a child with ASD in a rural community who's not able to tap into services because of access challenges, we now have that underdiagnosed and undertreated phenomenon. And if they ultimately do get treated, and, as you know for ASD, time matters, there's a risk for delay in diagnosis and the complications that happen with that. I would see this every time in my clinical practice. Your geography absolutely will define your health status.

Rep. Hawkins:

[02:38:08](#)

Absolutely. As a child, my youngest used ABA therapy, and it was very successful for his growth and development and ability to engage in the classroom and with others. One thing that I have respected, and I hope that we can maintain about this discussion publicly and in this committee, is that the services for autism and ABA therapy are not to be demonized. Because one of the things that I want to make sure that is incredibly clear is that, if you do so, even under the guise of fraud, waste, and abuse, people will go back into the shadows because they will

think that they are not needed to be provided those services and that somehow they are cheating systems that they're only now being exposed to. So, that's really, really important to also say.

[02:38:53](#)

A follow-up question for you related to that is, do you expect more growth? Because I think that's sort of leading the witness here a little bit, but if you're saying that in rural communities, outside of the sort of 15 urban counties, that we're seeing underdiagnosis in rural communities, that means, as we correct ourselves internally, but as more people are getting diagnosed and as North Carolina grows, even in rural areas, we're going to see more growth. How do we make sure that we are both guiding the General Assembly, using best practices, and making sure that we're preparing rural communities to be ready for those new ASD and other IDD new commitments and the costs that will come along with that?

Mr. Sangvai:

[02:39:40](#)

Sure, I appreciate your question. I want to go back to a comment that you made, and I appreciate you sharing the story of your son. The outcomes that you described about being classroom-ready, that's how we measure the value of ABA services, metrics like that, and we have to apply that to any service that we provide through the Medicaid program. We need evidence that it's making a difference. To the extent of what the impact is going to be on rural, I've seen some estimates to say that we're coming to a plateau in North Carolina in terms of the numbers who might benefit from ABA therapy. There's always the chance that it can grow. This is all the more important that if the number of individuals who need those critical services is going to grow, that we do everything we can, that only those who are going to benefit from the service, the right amount of service, the right units of service, are the ones who get it.

Rep. Hawkins:

[02:40:29](#)

Yep. Another follow-up. ABA, I think, has been the most popular piece. And one thing that's also important for people to know is the statement in my last question, Mr. Chairman, it is one of the only few services that is provided to the autism community, and people and parents who are in need of those services will jump on the first available service that can be paid and supported. That's another reason for growth. Because, again, I know that most of the committee is not engaged deeply in that community, parents are looking for something. And when it is made available, they will use that service. That's another reason

for growth and development, but there are also other ways to support them.

[02:41:16](#)

Do we expect, because of the growth of diagnoses, which will continue to go up—I think you said plateau—but there are so many people, especially in rural communities, who are in waiting lines because they cannot get diagnosed. I know that there are more. How do we serve them outside of things like ABA? I think that's important for them to know. And how also will that connect to Medicaid cost?

Mr. Sangvai:

[02:41:42](#)

Thank you for that question. One of the byproducts of this ABA debate has been a coming together of like-minded individuals, and I just think it's that opportunity to convene those individuals to think about what else we can do because it's not the only thing that we might be able to do. I went to medical school at a time when we were told that autism has no treatment options and look at where we are today. It's not that whether or not we use it. We may have to make sure those services are going exactly to the people who need it and in the right amount, and that's going to allow us to make sure that whatever is available then can be available for others who need those services.

Rep. Hawkins:

[02:42:22](#)

And then, last... Sorry, I did say last thing, but this means the last one. We would love to... When do you plan to put forth those recommendations for the 20 recommendations to close the loops? You mentioned one that Representative Quick pursued about sort of out-of-state entities being more engaged in North Carolina. I know some of that has to do with the structures that we have to support.

Mr. Sangvai:

[02:42:47](#)

Sure.

Rep. Hawkins:

[02:42:48](#)

Will we be in a place to use more in-state brick-and-mortar opportunities versus telehealth? Because that was one of the goals of that bill that we did in 2021 was to make sure that North Carolina was able to build its own in-state operation eventually so that we did not have to depend so much on the out-of-state entities.

Mr. Sangvai:

[02:43:08](#)

Sure. There may be collateral impact from the change in the clinical coverage policy that was recommended, including local providers figuring out how they can be more available, particularly in rural communities. The process for us to make a clinical coverage policy change has to go through a process

where we have to post what we're going to recommend as a change to the clinical coverage policy. We have to post that for a certain number of days. And then if there is a response, we need another time period for additional commentary. When we compress that timeline and we look at what we're able to do, we think 20 of the 22 recommendations can go live on August 1.

- Rep. Hawkins: [02:43:50](#) Fantastic. Thank you so much, and I hope that we're able to support you in any way possible, definitely by supporting a state budget, but, secondly, by making sure that any recommendations that are legislative, we are standing directly beside you because this is an important issue, and we thank you for your service.
- Mr. Sangvai: [02:44:06](#) Thank you.
- Rep. Campbell, Chair: [02:44:07](#) Mr. Secretary, there's only two left in my queue, and I appreciate your patience.
- [02:44:11](#) Chair recognizes Representative McNeely.
- Rep. McNeely: [02:44:16](#) Thank you, Mr. Chairman. Director Sangvai—I hope I'm saying that right—true or false, especially with the expansion in Medicaid, are we not allowing over 10% of non-US citizens to receive Medicaid benefits? And I've heard a higher number than that.
- Mr. Sangvai: [02:44:40](#) Thank you, Representative. If only given the option for two answers, the answer is false.
- Rep. McNeely: [02:44:45](#) Okay. Well, maybe let me re-question that. How many non-US citizens are receiving Medicaid in North Carolina, and what's it costing the citizens of North Carolina?
- Mr. Sangvai: [02:44:55](#) Sure. I think in order to answer the question, we have to look at how an individual becomes eligible for Medicaid services. In order to become Medicaid-eligible in North Carolina, you have to apply. As we've identified, there are at least two pathways to apply. One is through the federal Exchange, and the others will go to your local Department of Social Services and apply. The individuals in the local Department of Social Services have a number of criteria they need to apply, including determining as to whether or not that individual is in the SAVE database. That is a database that allows you to check whether or not someone is a documented individual in the state of North Carolina. So, there is a filter in place that has to determine if somebody is

documented versus undocumented in order to receive services. We have a filter in place at that county level.

[02:45:55](#)

There's a second filter. The beneficiary eligibility process goes through five separate audits. Counties audit their own practices on an annual basis. We have an annual state audit. There is an audit mandated by CMS, and there are two separate audits. One is called a REDA audit and [the other] a PERM audit. The REDA audit helps us determine how many people in total are deemed eligible who are otherwise not eligible, and North Carolina scores in the 98% on the REDA audit. There's also something called a PERM audit, which allows us to determine if in fact somebody was not eligible for services and later determined to get services, what tools are available to recoup those dollars. That's also scored on a national level. Our PERM audit score is 0.46%. The national is somewhere around three-and-a-half to five percent. So, when you look at those five audits, the filters that we have at the county level to determine who's eligible, the likelihood that anyone who doesn't meet an eligibility criteria finds themselves eligible is exceedingly low.

Rep. McNeely:

[02:47:07](#)

You do believe that if you're a non-US citizen, you should not receive Medicaid benefits in the state of North Carolina?

Mr. Sangvai:

[02:47:14](#)

The North Carolina Medicaid program follows state and federal law. And if you are not eligible as you've described, then you should not get Medicaid services.

Rep. McNeely:

[02:47:25](#)

Okay. You believe that we're not supplying any Medicaid benefits to non-US citizens in the state of North Carolina?

Mr. Sangvai:

[02:47:32](#)

Yeah. The only chance, one opportunity, that there could be somebody who is non-eligible is if they were deemed eligible but are in that period before their redetermination where they're no longer eligible. For example, if somebody has eligibility today because they meet the income threshold and then they no longer meet the income threshold, that would be captured in that redetermination process. And then, at that point, that individual, because they didn't meet that criterion, would not be eligible for Medicaid.

Rep. McNeely:

[02:48:07](#)

Has DHHS discovered anybody that is a non-US citizen that is getting Medicaid benefits in the state of North Carolina under your term or under your knowledge?

Mr. Sangvai:

[02:48:18](#)

To my knowledge, no.

- Rep. McNeely: [02:48:19](#) Okay. But you would be willing to make sure that nobody that's a non-US citizen should receive these benefits then, correct?
- Mr. Sangvai: [02:48:31](#) Sir, the citizenship requirements, like any other criteria, we want to make sure every criterion is met for anybody. Whether it's what you outlined, income, or any of the other things that we need, we want to make sure only those who are duly eligible to receive Medicaid should be in the Medicaid program.
- Rep. McNeely: [02:48:48](#) If you did find non-US citizens receive it, you would alert authorities of that, correct?
- Mr. Sangvai: [02:48:55](#) The manner in which someone is identified as being non-eligible occurs at the county level, and so, the counties would then be able to... It's the county that determines that that individual is not eligible.
- Rep. McNeely: [02:49:12](#) Good. But you would be willing, for your agency, to distinguish that they are not eligible and allow authorities to know that?
- Mr. Sangvai: [02:49:20](#) That decision is made at the county level. The counties make the determination whether or not someone is eligible for Medicaid or not.
- Rep. Campbell, Chair: [02:49:29](#) Mr. Secretary, I'm afraid I gave you some disinformation. Now, you have two left.
- Mr. Sangvai: [02:49:34](#) Oh, okay.
- Rep. Campbell, Chair: [02:49:34](#) Thank you.
- [02:49:35](#) I'm going to recognize Representative Cervania.
- Rep. Cervania: [02:49:39](#) Thank you, Chair.
- [02:49:41](#) Secretary, I'm going to walk through some information that I know, and then please correct me or not correct me, and then I'll ask a question afterwards. In my work in this space, what I have been experiencing is that Medicaid is going through transformation, right? We're now not just only looking at physical health, but integrating health—physical, and behavioral health together—especially when it comes to services in our LME/MCOs and other providers of Medicaid, and possibly even medicine, which would be incredible. Our entity here, the House, has expressed the hope of providing more behavioral health services, but I want to go backwards in the series of

questions that were asked by my colleagues. There are some providers, and I can't say if they're fraud or not fraud or whatever, but a lot that was expressed were behavioral health providers. We've had decades that Medicaid has reimbursed for medical services with great codes and everything like that, but we're still in a... Secretary, are we still in a fledgling time to really identify codes, policy when it comes to behavioral health and integrated health when it comes to serving our Medicaid population?

Mr. Sangvai: [02:51:16](#)

Thank you for that question, Representative. I think one of the best things North Carolina did—the General Assembly did—was when we looked at how do we support the behavioral health system in North Carolina and with the expansion bonus appropriating \$835 million specifically for behavioral health. I think one of the things that the behavioral health science has learned over time is: 20 years ago, behavioral health was, "You need to see a psychiatrist." Maybe 15 years ago, it was, "Maybe you don't need to see a psychiatrist. Maybe you need a psychologist." And we're starting to recognize that each professional in the behavioral health ecosystem has a skillset. We realize that not everybody needs the same thing. It's not a one-size-fits-all model. We know that individuals who need MAT, some do not want to go to a specific location and will prefer mobile MAT, but we learned that because we tried that. We use evidence to help us figure out what service is going to work under the best circumstance.

[02:52:20](#)

We have seen that the number and type of providers in behavioral health have grown. The vast majority are trained, educated, licensed, certified—all the important things we want to do to make sure that they are truly a credible provider in that space. So, this is the opportunity now before us and I don't believe we're fledgling, I believe what we need to kind of identify is how to create the network that we can so we can focus on what the agency has always focused on. If you are an individual who has a behavioral health need, you need someone to call, someone to respond, and a safe place to go. And if we think about that as a framework under which we are building the behavioral health ecosystem in and out of Medicaid, I think we're on the right track, but we have a lot of work to do.

Rep. Cervania: [02:53:07](#)

Thank you so much on that. And I think that, including myself, there needs to be more clarity on what type of work that identified provider and all of that space could be. Is there a resource that your agency can provide us or on a website that

helps us understand what the department is considering credible, high-quality provider type services that are in that space?

- Mr. Sangvai: [02:53:43](#) Sure. That's another great question. As you think about this universe of providers, how do you distinguish between one versus the other? How do you pick the one that's right for me is I think the question that you might be asking. I'm not sure if we offer a specific resource, but I know we have the talent in our Division of Mental Health that will help us think through how we can craft a model where, if someone was saying, "Hey, I need help. How do I get it, and what type of provider is right for me?" It sounds like such a cool idea. I wouldn't be surprised if we already thought about it, and I'm embarrassed if we haven't, but I'm excited if it's something that we can build.
- Rep. Cervania: [02:54:20](#) Wonderful.
- Rep. Campbell, Chair: [02:54:20](#) One additional question.
- Rep. Cervania: [02:54:22](#) One of my last question-
- Rep. Campbell, Chair: [02:54:23](#) One addition.
- Rep. Cervania: [02:54:24](#) Yeah, the last one is that, again, as I asked the Attorney General, what can we as a legislature help support in the agency when it comes to our commitment to want to... We say we have a commitment towards improving our behavioral health and also the integrated approach in Medicaid. What can we do to help support the agency and all the providers to be able to provide that?
- Mr. Sangvai: [02:54:51](#) Thank you again for that question. I wish I could come up with something that was more eloquent than what the Attorney General said, but it's exactly what he said. It's the opportunity to continue to stay engaged, dialogue like this. If there's something where there are great ideas that members have identified, share those with us because we're always looking to figure out how to do continuous improvement to reach those objectives.
- Rep. Campbell, Chair: [02:55:16](#) Thank you.
- [02:55:17](#) Chair recognizes Representative Cunningham.
- Rep. Cunningham: [02:55:19](#) Thank you, Mr. Chair.

[02:55:21](#) Mr. Secretary, this is going to be an easy question. Is there an age range that ABA therapy is most effective and are there any studies that provide data outcomes related to the age that they're receiving the therapy?

Mr. Sangvai: [02:55:36](#) Thank you for that question. I'll make sure that if we want very specific data, we look into the group of experts that we have. ABA therapy, as I understand it, has its highest impact in individuals who are diagnosed earlier—so, younger kids. We start to see probably... if you kind of think from the schooling standpoint in that elementary school to maybe middle school area, but there have been cases where individuals as old as 21 may benefit from it. The important thing about it is that this is where one of the things we're stressing is going to become so important. Treatment needs to be individualized. When you individualize treatment, one of the most important things you can take into consideration is not only the severity of disease but the likelihood of success based on where in your stage in life that you're getting treatment.

Rep. Campbell, Chair: [02:56:30](#) Thank you, Representative Cunningham.

[02:56:32](#) Mr. Secretary, thank you for being here. I know this was a three-hour gauntlet, and I appreciate your time.

[02:56:37](#) Members, thank you for your questions.

[02:56:40](#) And thank you both, Secretary Sangvai and Attorney General Jackson, for your insights today. I do want to say that every dollar of waste, fraud, or abuse that is unrecognized, unenforced, ignored is a dollar that's not available for North Carolinians that need care. We have some work ahead to restore public trust from program eligibility to provider oversight. Accountability must guide every step. This committee will continue to press for stronger data analytics, faster enforcement, and better use of federal partnerships to identify and stop waste, fraud, and abuse before these dollars are lost.

[02:57:18](#) Members, thank you again for your attention and dedication. Seeing no further business, this meeting is adjourned. Thank you.