



The NC Medicaid Managed Care Ombudsman: A Robust and Effective Beneficiary Support System

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State Medicaid programs that use managed care generally must have a support system for those enrolled in managed care plans. However, these programs vary widely both in design and effectiveness. When implemented well, these Beneficiary Support Systems (BSSs) play a critical role in helping Medicaid enrollees address issues and access care. They also are important for accountability purposes because they track issues and identify systemic problems for some managed care populations.

When North Carolina's legislature decided to move much of the Medicaid population to comprehensive managed care, the Medicaid agency included a robust BSS that would serve all enrollees as a core part of its managed care transformation. As with other components of the transformation, the Medicaid agency engaged in significant stakeholder feedback regarding the design of the BSS. The resulting North Carolina Managed Care Ombudsman (NCMO) launched in 2021 before people began transitioning to managed care plans. Operated by several state-based legal services organizations, the NCMO implemented the BSS to, among other functions, meaningfully provide outreach and education, assist enrollees with issues, and track enrollee issues to identify systemic problems. The NCMO also provided trend reports to the Medicaid agency along with ombuds' suggestions about how these issues could be resolved.¹ For four years, the NCMCO served as an access point for complaints and concerns and served an important role in managed care accountability. Although the NCMO as originally designed and implemented unfortunately ended due to funding shortfalls, it is an example of the effectiveness of a robust BSS that should be replicated in other states to improve enrollee experience and managed care accountability.²

The Role of Beneficiary Support Systems in Medicaid Managed Care

Over the last thirty years many states have transitioned from a fee-for-service delivery system to managed care to provide Medicaid coverage to beneficiaries, with 78% of Medicaid and CHIP beneficiaries enrolled in a comprehensive managed care organization (MCO) as of 2024.³

As the prevalence of managed care has increased, so has the need for protections and assistance for beneficiaries enrolled in such systems.

Since 2018, states with Medicaid managed care have been required to have a beneficiary support system (hereinafter BSS).⁴ A BSS provides some types of assistance to all managed care enrollees, and it must provide a subset of additional services specifically designed for individuals who receive or express an interest in receiving long term services and supports (LTSS).⁵

A state's BSS is charged with several crucial imperatives. For all managed care enrollees, a BSS must provide: choice counseling, assistance for enrollees in understanding managed care and accessing LTSS, and outreach. If an enrollee uses or expresses a desire to receive LTSS, the BSS must provide the following additional functions:

- Serve as an access point for complaints and concerns about managed care enrollment, access to covered services, and other related matters;
- Education on grievance and appeal rights within managed care; the state fair hearing process; beneficiaries' rights and responsibilities; and additional resources outside the MCOs; and
- Assistance, upon request, with navigating the grievance and appeals policy within the managed care system as well as appealing adverse benefits determinations by the managed care entity to a fair hearing; the BSS may not represent enrollees at a fair hearing.⁶

The BSS also serves an important oversight and accountability function. It is expected to compile and review data from the LTSS program, and share this data with the state Medicaid agency for the purpose of identifying, remediating, and resolving systemic issues.⁷ Although the BSS has an oversight function, it does not provide any direct oversight of a managed LTSS program as the state Medicaid agency retains ultimate responsibility.⁸

Although the BSS does not provide direct oversight, it serves an important role in managed care accountability, primarily because it is an access point for complaints and concerns, along with education and referrals to legal representation if necessary.⁹ Providing education about the options that enrollees can choose for issue resolution facilitates enrollees' filing complaints and grievances about problems, which is important data the plans are required to report.¹⁰ The trend monitoring and identification of systemic issues also plays a key role in managed care plan accountability as the state can better identify issues that are plan specific, including problems like network adequacy, improper application of policies, etc. and the BSS can provide recommendations and guidance to the state to address systemic problems based on its

experience with enrollees and the plans.¹¹ For more on accountability and examples of how the NC BSS and others perform this function, *see infra* [Using the Ombuds as an Accountability Tool: NC & Beyond](#).

Nearly a decade after the Medicaid Managed Care Rule required states to have an LTSS BSS, there is a great deal of variety in the design and function of each state's BSS. Some states interpreted CMS' guidance to "leverage existing resources" to develop a BSS to mean that states could use existing customer support systems and community organizations, without providing additional resources or structure.¹² Other states have assigned the BSS duties to a part of the Medicaid agency that may be carrying out a myriad of other functions, or have small, specific sections of the agency performing the task.¹³ States that embrace the accountability and advocacy intent of a BSS have contracted with external entities to perform the functions. And then a rare few states have recognized that the mandated function provides valuable support to a broad group of Medicaid populations navigating managed care beyond just the LTSS population. A BSS that provides broader services is able to gather significant data that better equips a state Medicaid agency to hold its managed care plans for the services and quality of care for which they are contracted to provide.

North Carolina's Distinctive BSS Model

North Carolina launched a robust external BSS shortly before it began transitioning its Medicaid population into comprehensive managed care plans over the course of several years. This BSS, known as the North Carolina Managed Care Ombudsman (NCMO) was operated by legal services providers as an external entity for about five years. The NCMO served all managed care enrollees and was credited with providing a critical beneficiary protection in research evaluating the State's first year of comprehensive managed care, and in subsequent years played an essential role in outreach, advocacy, addressing problems, and tracking systemic issues through trend monitoring.¹⁴ This important program took time and stakeholder engagement to create, and work from the legal services organizations to meaningfully implementing the concept. The resulting BSS was a model for other states that handled over 100,000 calls, and tens of thousands of cases with a resolution rate as high as 98 percent.¹⁵

Moving from Primary Care Case Management to Comprehensive Managed Care

North Carolina's Medicaid transformation began in 2015 when the North Carolina General Assembly enacted legislation directing the transition of Medicaid from fee-for-service under a primary care case management (PCCM) model using local community networks to statewide comprehensive managed care.¹⁶ North Carolina relied on its PCCM system for several decades and realized significant savings over the years.¹⁷ Despite the success of the PCCM program,

legislators pushed to move to a design that relied largely on commercial managed care plans. Legislators described their goals as follows:

- Ensure budget predictability through shared risk and accountability.
- Ensure balanced quality, patient satisfaction, and financial measures.
- Ensure efficient and cost-effective administrative systems and structures.
- Ensure a sustainable delivery system.¹⁸

From early days, the Medicaid agency engaged in a very public process for designing and implementing the transformation directive of the legislature, including seeking stakeholder input at various stages and through different mechanisms.¹⁹ The Medicaid agency used a Section 1115 demonstration to implement the design, which also included public comment periods.²⁰ The state Medicaid agency phased-in the managed care transformation, beginning with most Medicaid enrollees (1.6 million) into regional and statewide Standard Plans on July 1, 2021.²¹ Several years later, after a few postponements to ensure readiness, the State transitioned those who required specialty behavioral health care (210,000) into Tailored Plans on July 1, 2024, with children, youth, and families involved in the foster care system (32,000) enrolled in a specialty plan on December 1, 2025.²² During this period of transition, the legislature also approved Medicaid Expansion, enrolling over 600,000 into the system within the first year.²³ Although the state previously had some capitated managed care for certain behavioral health services, the move to managed care for most services was a significant change for nearly all of NC's Medicaid population.²⁴ The role the BSS played in this significant population and delivery system shift was critical.

Designing A Meaningful BSS in Partnership with Stakeholders

As part of the transformation design process, the NC Medicaid agency published policy papers for public comment, including several on their approach to beneficiaries, LTSS, and care management.²⁵ Through commenting on policy papers and Section 1115 demonstration drafts for comment, advocacy to the Medicaid agency, and other mechanisms, Medicaid advocates provided feedback on key features of the managed care transformation. Early on, Medicaid advocates pushed for a robust BSS that would fully meet the regulatory requirements in a meaningful way and would do so for the entirety of populations enrolled in managed care.²⁶

A BSS needed to provide meaningful support itself for enrollee problems, and if a referral was appropriate, the BSS could not simply be part of a referral whirlpool that would send enrollees to sources that might be able to assist them; it needed to be the last stop or the next to last stop for people seeking help. Advocates provided comments on other aspects of the BSS, including key design features and functionality, including that the BSS be operated by an

entity outside of the state agency with strong knowledge of Medicaid beneficiary rights. Because of prior experience with rights violations due to discouragement of filing grievances and appeals, advocates insisted that the resolution features of the BSS in no way interfere with an individual's rights to file grievances and appeal.²⁷

Since early transformation planning, the Medicaid agency ("the Department") expressed a desire for strong feedback mechanisms throughout the design.²⁸ The Department had experience with managed care plans for behavioral health services that informed their design choices for monitoring and accountability measures, including support for enrollees.²⁹ It also strongly promoted feedback loops, with an emphasis on enrollee experience. A few members of Department leadership helped support many of the ideas presented about a robust external BSS. In early policy papers, the Department identified four key features of an Ombudsman Program: **Education, Advocacy, Issue Resolution/Enrollee Assistance, and Trend Monitoring**.³⁰ Other key features included that the program would be external to the Department, it would begin before populations transitioned, and other entities within managed care would be required to work with the BSS to address enrollee complaints.³¹ Although the core functions remained largely the same, determining how to make this work and the minimum function requirements would take further work and feedback efforts. For more details on how the Medicaid agency used feedback loops, including public comment and advocates' efforts to influence the design of the NCMO, see [Appendix A](#), Designing the NCMO: How Feedback Loops Informed Key Features, *infra*.

Although the Request for Proposal for the contract for the Ombuds Program was issued on May 30, 2019, it received several extensions.³² The Department ultimately awarded the contract to Legal Aid of North Carolina in partnership with the Charlotte Center for Legal Services and Pisgah Legal Services.³³ This group of NC legal services organizations had extensive Medicaid experience as well as a strong history of outreach, education, referrals, and working with communities across the state.

As a result of its design efforts, the North Carolina Medicaid agency developed an intentional and comprehensive resource for all Medicaid managed care beneficiaries, not just those in LTSS, that also increased oversight of managed care plans and services issues.

North Carolina's Provider Ombudsman

Through the managed care transformation design process and the development of the NCMO, Medicaid providers recognized many features they would find helpful in their own transition to managed care. The Department established a Provider Ombudsman program, which was operated by a different entity than the NCMO. The duties of the Provider Ombudsman launched earlier, in May 2020, and within the first 90 days handled a significant number of questions. It was important in triaging provider questions to make it easier for them to understand the changes, and contract with managed care plans so that they would be in the plan's provider networks. The Provider Ombudsman helped enrollees not lose their existing providers and have fewer gaps in care during the change to managed care.³⁴

Putting Ideas into Practice: How the NCMO Implemented Core Features

The legal services organizations awarded the NCMO contract had extensive experience helping people navigate the Medicaid program, informing them of their rights, providing outreach and education, and tracking their results. Implementing the NCMO as designed by the Department was a bit of a different task.³⁵ However, many of the core features of the NCMO were patterned after tried and true legal services best practices:

- **Outreach:** Before an NCMO could be effective, Medicaid managed care enrollees needed to know that the program was available and how to access it. From the outset, the NCMO partnered with recognized organizations and reached out to local community groups to ask what each community needed and what type of methods worked best for each population.
- **Access:** Next, beneficiaries needed to easily be able to request help without delay. They should not be required to use magic words or submit a written application to get assistance. They also had to be able to connect through multiple modalities such as through phone, internet, in-person, and via auxiliary aids and services when requested. The NCMO streamlined a process for ombuds and beneficiaries to connect.
 - Ombuds staff were also trained to employ cultural and linguistic competence in outreach to all Medicaid populations including those with limited English proficiency, cognitive disabilities, and other potential communication barriers.
- **Referral:** The referral process would need to be highly targeted so that the NCMO was either the last stop or next to last stop for a beneficiary seeking assistance and a "warm handoff" to the next resource would be provided where possible. To accomplish this, the NCMO developed open communication with departments of social services, the

provider support system, managed care departments, legal services organizations, etc. to understand the service areas these organizations covered and any limitations that would prevent the referral organization from providing needed assistance.

- Ombuds staff also explained to enrollees why the referral source is the best option and what the enrollee could expect after the referral is made. Only then would ombuds provide a warm handoff to another organization, with follow-up with the referral and the enrollee, monitoring the case until the issue was resolved. The NCMO used numerous tools to track these cases until resolution, sometimes up to 90 days.
- **Issue Resolution, Not Discouragement:** While NCMO staff could not represent enrollees in their appeal of an adverse benefit determination such as a denial of services, ombuds were well versed in educating enrollees about their rights, including to proper notice of a decision about their benefits, the right to grieve that decision, and the right to appeal the decision to a state fair hearing.³⁶ It was critically important for ombuds to be adequately trained to help beneficiaries to understand their legal rights and all options available to them and to communicate these processes to beneficiaries without discouraging them from filing grievances or requesting fair hearings.
- **Identifying Systemic Issues:** The NCMO was charged with assessing the systemic issues in the managed care program. To that end, the NCMO tracked issues and drafted trend reports that were sent to the NC Medicaid agency monthly along with ombuds' suggestions about how these issues could be resolved. The NCMO also conducted monthly webinars wherein beneficiaries were taught about systemic issues and how these issues could be resolved independently.
- **Tracking Performance:** As required, the NCMO used specific quality metrics to ascertain its effectiveness.³⁷ The NCMO tracked: How quickly were enrollees able to receive assistance? Was there a mechanism to flag beneficiaries who had pressing deadlines? Were enrollee issues resolved with the initial NCMO assistance or were more issues referred out to other organizations? What was the result of those referrals; how many were fully resolved with a positive outcome, such as a reversal of the plan's original decision?

The following is an overview of the process used by NCMO staff upon contact from a Medicaid member, or someone requesting help on their behalf:³⁸

- **Ombudsman investigation and documentation.** The first step for each call was to identify and document issues and establish trends. This was done by:
 - Asking questions to determine what occurred by the time the beneficiary contacted the NCMO. This step was critical to determine the best course of

- action to take to ensure deadlines are not missed if the caller is already in the appeal stage.
- Conduct three-way calls with external entities to confirm system data.
 - **Resolved “known” issues (problems the NCMO identified as common and developed an established process to resolve).**
 - Ombuds used a tier based, decision tree style problem solving (i.e., if step 1 fails, move on to step 2) to determine if the issue is within the scope of the NCMO.
 - Regardless of scope, a **“No Wrong Door”** approach was used, and the Ombudsman provided referrals as resources permitted.
 - Ombuds used NC Medicaid approved scripting when available or NCMO approved process documents if scripts did not exist for instructions on next steps.
 - Engaged the care manager with the health plan when relevant.
 - Tier 2 – Engaged points of contact with the local departments of social services, health plans and transportation vendors.
 - Depending on the severity of the problem, ombuds helped to file a grievance if a health plan was involved, and the issue could not be resolved through the plan’s Member Services Department.
 - Tier 3 – Escalation and consultation with NC Medicaid.
 - Tier 4 – Legal referral.
 - For “new” issues (recently identified trends or unique call issues where no script or NCMO process existed), before following the steps in #3 above, the NCMO created a process by:
 - Adding a data collection mechanism to case management software to track frequency of new issue and alert staff to new potential issue trend and how to report
 - Notifying NC Medicaid of emerging trend, consulted with them on possible resolution strategies or responsible parties
 - Studied, tested and implemented potential resolution models
 - Formalized a process/referral procedure to resolve new issue
 - Disseminated new process information to program staff via training and written instructions and added to training database for new hires

The End of the External North Carolina Managed Care Ombudsman Program

The NCMO had been heralded as a success by researchers and was relied upon by stakeholders throughout the state. Unfortunately, the Department ended the contract for the external NCMO, citing a \$33 million shortfall in their Medicaid Managed Care Oversight Fund.³⁹ As of January 1, 2026, the Department’s Division of Health Benefits (DHB) would perform the

essential functions of the NCMO with reduced services.⁴⁰ The announcement provided no further information on what the “essential functions” would now be.

There is a significant difference between the BSS functions required by regulation, and the functions of the Ombuds Program presented in the original RFP. For example, although the “no wrong door” approach had been a key feature of the Ombuds Program since early design days that allowed people to seek assistance through multiple modalities and avenues, the announcement merely identified that the NCMO number would remain the same and the NCMO website would redirect to a new page on the North Carolina Medicaid website.⁴¹

The announcement also indicated that people would be referred to their managed care plan for resources in certain circumstances. At the time of the announcement, it was unclear what the staffing at the Department would be for the program, much less what their training would be or what the referral process would be, if any. There was also no information about what kind of data would be tracked under the new setup, how conflicts of interest would be addressed, protections for enrollee rights, and other features that were important to the NCMO design. The move from an external BSS operated by legal services organization with fidelity to the Ombuds Program design developed in collaboration with stakeholders, to an internal function within the State Medicaid agency is a major setback for North Carolina Medicaid enrollees, other stakeholders, and accountability of Medicaid managed care in North Carolina.

Using the Ombuds as an Accountability Tool: NC & Beyond

The Medicaid managed care regulations require states with capitated managed care to establish a BSS that includes counselling to help applicants choose their managed care plan and assistance for enrollees to understand how managed care works.⁴²

The regulations for a BSS also lay out additional requirements for enrollees who use long-term supports and services, ranging from institutional nursing facility services to care provided in home and community-based settings, such as home health, personal care, and private duty nursing. These requirements include providing an access point for complaints and concerns, educating enrollees about their grievance and appeal rights, and providing assistance in navigating that process, including providing referrals to legal representation if necessary.⁴³ Finally, in addition to helping enrollees solve the problems they encounter engaging with the managed care system, Medicaid regulations require these BSS entities to fulfill a review and oversight role that works back up the chain to provide recommendations and guidance to the State to address systemic problems.⁴⁴

While these requirements are not mandatory for managed care systems outside of LTSS, they are exceedingly smart policies. Robust ombuds programs have regular direct contact with beneficiaries across the state, and these contacts provide a unique perspective and capacity to identify systemic problems like computer errors, improper denials, and even suspicious activities. Although the regulations generally require a BSS to provide review and oversight LTSS program data, a strong program can play a meaningful accountability role. This is exactly what North Carolina did when it established its BSS and required the program to report regularly to the State on patterns they found in their caseloads. One NCMO staffer nicknamed the ombuds as “a filter house of people’s problems.”⁴⁵ The structure that brought caseworkers together to collaborate allowed them to identify less common issues that may never have been noticed if the cases were handled by separate, uncoordinated offices around the state.

The NCMO identified trends in monthly reports. Staff met regularly to discuss these trends, and these discussions and the process of compiling and writing trend reports helped them uncover patterns, including flagging cases of fraud, sometimes the same day they began receiving similar calls.⁴⁶ Trend monitoring of this type also helped identify training needs for State eligibility officials. Even when the State did not offer an immediate fix for an identified problem, ombuds staff were often able to develop and share manual workarounds.

By identifying these problems early and reporting regularly to the State, the NCMO helped the state correct problems that improved program quality and likely saved money by reducing errors and avoiding other consequences. Although a critical part of the design of the program, the NCMO often did not have to do formal referrals to legal services.⁴⁷ The system facilitated the informal resolution of many cases, which ended up helping beneficiaries and being cost-effective to the state.⁴⁸ Unfortunately, there is no indication the state collected or evaluated metrics on how much these practices may have saved the state.

The NCMO’s model of tracking and reporting systemic trends is unusual for Medicaid programs, but not unique. New York uses a similar coordinated ombuds model in its Managed Long-term Supports and Services Program (see box below). Missouri also has an ombuds function run through legal services organizations for its managed care program. Information about contacting the Missouri ombuds, known as Advocates for Family Health, is included in every denial notice or other adverse benefit determination that plans send to an enrollee.⁴⁹ Anyone that has an MCO issue in the state can call AFH and become a client. A call to a single number will get any enrollee statewide a referral to the appropriate AFH office. The Missouri managed care contract requires each plan to meet with the consumer advocates on a regular basis, and over time these meetings have developed a foundation for activities and for the ombuds to discuss issues and problems with the plans directly.

New York's Independent Consumer Advocacy Network (ICAN)

In 2011, New York implemented a mandatory managed Long Term Services and Supports (MLTSS) program for adults eligible for both Medicaid and Medicare who needed home care. As part of that planning process, the State worked with advocates to establish a statewide consumer ombudsman program, known as ICAN. Managed by the Community Services Society of NY (CSS) and a statewide network of non-profit legal advocacy and other community-based organizations, ICAN today acts as a Medicaid Beneficiary Support System (described above), including the LTSS-specific features, for Medicaid beneficiaries who need long term care or behavioral health services. Following the requirements for BSS, the ombuds obligations include performing a "sentinel function" to identify potential rule violations by plans, monitor trends in their complaints receives, and elevate key issues up to the State.⁵⁰

Like in North Carolina, New York ombuds staff attribute their success partly to strengthened relationships with state officials that focus on problem-solving to resolve policy implementation issues. ICAN has liaisons with each contracted health plan and often can address individual issues with a call to a care manager. The integrated statewide network has helped staff quickly address new problems, including instances flagging potential fraud similar to the NCMO.

Unlike North Carolina's model, ICAN staff do not have the warm hand-off function to advocates who can represent consumers in Medicaid fair hearings. However, ICAN has been able to use New York's external appeals law as a tool to help individuals resolve services issues. This mechanism has turned out to often be faster and more predictable than fair hearings. Decisions in these external appeals are made by a doctor who is typically familiar with home care as well, which is often helpful. This structure thus helps reduce the need for fair hearings, which can relieve pressure on the State, especially if there is any hearings backlog. Like North Carolina, this BSS function can represent a win/win for beneficiaries and for states.⁵¹

ICAN also serves a role in beneficiary outreach and has sought to become involved with the state's required Medicaid Advisory Committee (MAC). This involvement allows them to use their knowledge and experience in Medicaid stakeholder feedback to improve the program. While limited in scope to MLTSS, New York's ICAN Ombuds Program shows that models similar to North Carolina's work elsewhere. This suggests they could be replicated effectively to other states and populations.

Conclusion

North Carolina, like many other states, chose to move its Medicaid program using capitated managed care. However, North Carolina was a bellwether in enhancing and expanding the required BSS functions for LTSS populations to develop a comprehensive and independent BSS that improved both the state's administration of the Medicaid program and the beneficiary experience for all Medicaid populations. It is crucial that the lessons learned about how this robust BSS conducted outreach and education; how it ensured access to its services across the Medicaid population; how it facilitated issue resolution and worked for systemic fixes; and how it was a critical part of managed care plan accountability are not lost. In fact, the critical features of the NCMO, like many of those in the New York and Missouri models, should be replicated in other states for the benefit of Medicaid managed care enrollees, providers, Medicaid agencies, and other stakeholders.

Appendix A: Designing the NCMO: How Feedback Loops Informed Key Features

As explained *supra* the North Carolina Medicaid agency engaged in significant public design process that solicited stakeholder feedback. This included design elements related to the enrollee experience and the BSS. Several of the policy papers that solicited public comment touched on these issues, to which advocates responded. Advocates also submitted requests regarding managed care design, especially regarding the BSS, without formal public comment opportunities and discussed it in stakeholder meetings with the Department. Participation in these feedback loops helped build design elements over time, adding detail and new considerations with each iteration.

Prior to the formal procurement process, the concept papers published by the Department were the main source of information as to plans regarding managed care design.⁵² Medicaid advocates responded to concept papers where relevant and possible based on capacity, but always when the topic included the Medicaid enrollee experience, including plans regarding the BSS. In 2018, the Department issued a Request for Information (RFI), in which the Medicaid agency described the “Ombudsman Program” as an entity that would:

ensure that beneficiaries and their legal representatives can obtain the information they need, get answers to questions or problems resolved in a timely and efficient manner, and, when necessary, be equipped to effectively advocate for themselves through the grievance and appeals system.⁵³

The RFI also described an organization external to the Department that would operate as a “no wrong door” resource that worked collaboratively with other parts of the system, including state agencies and community based organizations, and would assist enrollees with appeals if the Ombudsman’s approach to resolution was unsuccessful.⁵⁴ Stakeholders appreciated that in the RFI, the Department also recognized the program would:

- be more than a call center;
- include legal staff;
- serve as an advocate;
- employ staff with advanced knowledge of North Carolina Medicaid service systems;
- provide culturally competent services; and
- perform outreach based on community needs/features.⁵⁵

Although these features aligned with prior feedback, advocates had concerns with the RFI. They argued the NC BSS would need to not simply work with area non-profits to advocate for

beneficiaries, but must provide robust services itself and be operated by a community-based non-profit. The BSS could not simply triage calls and provide referrals. Additionally, advocates stressed the importance of creating a BSS that would remain independent from NC DHHS and other managed care entities to ensure that beneficiaries understood they had no incentive to decrease complaints, grievances, or appeals filed nor were they associated with plans or service providers when providing education. The RFI indicated plans for work with the enrollment broker that may have created or given enrollees a perception of conflicts of interest. Advocates reiterated concerns about the program unlawfully discouraging grievances and appeals under the guise of issue resolution.

In the Request for Proposals (RFP) that followed in 2019, the state addressed many of the advocates' concerns with the RFI and provided additional details about the required operations of the program.⁵⁶ The RFP also set forth the data elements the Ombuds Program would be required to track across its various functions. Some of the key features of the proposed program included:

- **Information & Education:**
 - Operate as a "no wrong door" information and access point that would provide relevant, current, and accurate information to assist individuals with access to care, whether through managed care or the fee-for-service program.
 - Be knowledgeable of the services of the other entities such as the enrollment broker, plans, and state/local entities that assist enrollees so that people were directed to the appropriate entity to resolve their issue.
 - Document data elements for information and education provided.⁵⁷

- **Issue Resolution:**
 - Ensure services are not construed to replace grievances and appeals, nor subvert the right to request an appeal. The program must not, in any way directly or indirectly, impede or limit any member from requesting any appeal at any time.
 - Develop and implement a clear system for clients to give informed consent regarding communications with other parties and the Program.
 - Respond to issues and concerns in a meaningful manner that involves more than just good customer service, but encompasses listening to the concern from the client's point of view, clarifying and clearing up any misunderstandings there may be, and striving to obtain the best and most efficient outcome for the client.
 - Providing meaningful issue resolution through one-on-one assistance; determining the best and most efficient action to take after an assessment of the issue; identifying the best possible resolution based on their presenting request; working with entities collaboratively within the BSS and other entities to resolve

the concern; and providing a warm hand-off where appropriate with needed materials.⁵⁸

- **Issue Management:**

- Develop internal policies and timelines that outline decision-making process by the Ombudsman for determining the appropriate course of action, including so that if a person calls back on the same issue they are directed to the same staff, or do not have to re-explain the problem.
- Use a case management system to track and report data elements for an issue from contact through closure, including when an issue was not satisfactorily resolved. The case management system must also track issues by “disposition categories” which would track what part of the program was at issue, and the type of problem.
- Report separately on complaints about the Ombuds Program.⁵⁹

- **Referrals:**

- Work collaboratively with community-based and legal assistance organizations to establish a collaborative referral system; including the use of formal agreements where necessary with external entities to provide a closed-loop referral system when it has been determined resolving the issue is beyond the scope of the Ombuds program core services, or the external entity can best meet the client’s needs. Track and report referral data elements.
- Establish a triage and assessment process for making the determination a referral is needed, including timelines to track resolution and follow up with the entity and the client.⁶⁰

- **Trend Monitoring:**

- Document trends identified during client interactions and contacts.
- Provide the Department with strategic solutions to assist the plans, enrollment broker, and Department with addressing potentially systemic issues across the managed care delivery system.
- Generate Trend Monitoring Reports that include, at a minimum:
 - Summary of any measurable trends in plan performance, broken down by plan;
 - Summary of measurable trends in enrollment broker performance; and
 - Recommendations on how to address identified issues and concerns.⁶¹

- **Communication, Engagement and Outreach**

- Develop, distribute, and maintain information and educational materials on Ombuds services in accordance with language, readability, translation, cultural competency, and accessibility standards described in the RFP.
- Make the materials available at outreach events hosted by the Program and in partnership with other entities, at community-based sites, and other sites, as well as electronically, in other formats, etc.
- Host a minimum number of events by type and on certain timelines, tracking required data on such outreach.
- Capture information on member experience through surveys and evaluation feedback.⁶²

After the RFP, advocates not involved with organizations that had responded to the RFP continued to ask questions of the Department and push for strong implementation of the Ombuds Program before Medicaid enrollees began transitioning to managed care. The contract for the Program was granted to Legal Aid of North Carolina with support from other legal services organizations in December 2020.

¹ Authors requested the trend monitoring reports generated by the NCMO as well as related NCMO documents as public records but had not received them by the time of publication. The publication will be updated or otherwise supplemented after receipt of the requested documents.

² See Andrew R. Jones, *\$33 Million Budget Shortfall Leads to Widespread Layoffs in Medicaid Ombudsman Program*, N.C. HEALTH NEWS (Sept. 21, 2025), <https://www.northcarolinahealthnews.org/2025/09/21/33-million-budget-shortfall-leads-to-widespread-layoffs-in-medicaid-ombudsman-program/> (reporting on a shortfall of \$33 million in the Medicaid Oversight Fund, which were cuts separate from the Medicaid rebase shortfall, as the reason for ending the Medicaid Ombudsman contract with legal services and moving the function internal to the Division of Health Benefits as of January 1, 2026).

³ Elizabeth Hinton et al., KFF, *10 Things to Know About Medicaid Managed Care* (Mar. 23, 2026), <https://www.kff.org/medicaid/10-things-to-know-about-medicaid-managed-care/>.

⁴ 42 C.F.R. § 438.71; see also Medicaid and Children’s Health Insurance Program (CHIP) Programs, Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, 81 Fed. Reg. 27,498-27,901 (May 6, 2016),

<https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf>. [hereinafter Managed Care Rule]; Elizabeth Edwards, Nat’l Health Law Program, *Medicaid Managed Care Final Regulations: Beneficiary Support Systems* (Oct. 14, 2016), <https://healthlaw.org/wp-content/uploads/2016/10/IB7MedicaidManagedCareBSSfinal2.pdf> (summarizing the 2016 rule changes that established the requirements of a BSS). CMS issued the rule requiring BSS in 2016, but states were not required to have a BSS until contracts for rating periods starting on or after July 1, 2018. Managed Care Rule, 81 Fed. Reg. at 27,499.

⁵ 42 C.F.R. § 438.71.

⁶ 42 C.F.R. § 438.71(d)(3). Although the BSS must provide assistance upon request with navigating the grievance and appeal process, it may not provide representation to the enrollee at a State fair hearing. It may refer enrollees to sources of legal representation. *Id.*

⁷ *Id.*

⁸ Managed Care Rule, 81 Fed. Reg. at 27,626.

⁹ 42 C.F.R § 438.71(d). Legal aid entities and similar types of organizations that represent beneficiaries at hearing may fulfill this role provided that they meet independence and conflict-free standards and that they establish organizational firewalls to keep the choice counselling separate from the part of the organization that represents clients. *Id.* § 438.71(c)(3); Managed Care Rule, 81 Fed. Reg. at 27,629-30

¹⁰ 42 C.F.R § 438.416.

¹¹ *Id.*

¹² Kinda Serafi & Patricia Boozang, Manatt, *Manatt on Medicaid: Beneficiary Support and Enrollment Requirements* (May 19, 2016), <https://www.manatt.com/insights/newsletters/manatt-on-health-medicaid-edition/manatt-on-medicaid-beneficiary-support-and-enroll>.

¹³ See Letter from Elizabeth Edwards for Nat’l Health Law Program, Disability Rights N.C., N.C. Justice Ctr. & Charlotte Ctr. Legal Advocacy, to N.C. Dep’t Health & Human Servs., Medicaid

Transformation (May 9, 2018) (on file with author) (collecting examples of how BSS function in other states).

¹⁴ Eva Allen et al., Urban Inst., *Findings from the First Year of Medicaid Managed Care in North Carolina 2* (Oct. 2022), <https://www.urban.org/research/publication/findings-first-year-medicaid-managed-care-north-carolina> (finding that the NCMO was critical because health plans were not adequately communicating or assisting beneficiaries during the transition from PCCM to Standard Plans). This study, funded by The Kate B. Reynolds Charitable Trust, examined the transition to managed care in North Carolina, including the impacts on access to and quality of care, and disparities in health outcomes among enrollees. The Urban Institute conducted interviews and facilitated focus groups to gauge the experiences of North Carolina Medicaid enrollees. The study found that although many of the 1.6 million initially transitioned to Standard Plans had few disruptions, there were several populations that had disruptions despite various provisions in processes to ensure continuity in care. Some with complex behavioral conditions were mistakenly enrolled in Standards Plans and many of those with high physical health needs reported challenges in accessing services and medications. *Id.* at 2.

¹⁵ Estimates based on data available for limited years of the NCMO contract. See N.C. Dep't Health & Hum. Servs., N.C. Medicaid, Annual Report for State Fiscal Year 2024 (July 1, 2023 - June 30, 2024) at 17 (2024), <https://medicaid.ncdhhs.gov/medicaid-annual-report-sfy-2024-english/download?attachment> (noting the NCMO answered 19,570 calls (18,456 English; 1,114 Spanish), participated in 218 outreach events with 7,984 attendees; and opened 16,030 cases with a resolution rate of 98%); N.C. Medicaid, Annual Report for State Fiscal Year 2023 (July 1, 2022 - June 30, 2023), at 16 (2023), <https://medicaid.ncdhhs.gov/documents/reports/annual-reports/ncmedicaid-annual-report-sfy2023/open> (reporting the NCMO fielded 41,185 calls (38,141 English; 2,652 Spanish; did 173 events with 6,769 attendees; and opened 17,421 with a resolution rate of 98%). The report for SFY 2025 included no information on the NCMO, SFY2022 report did not contain numbers, nor did the SFY2021 report. See generally N.C. Dep't Health & Human Servs., Annual Reports and Tables, <https://medicaid.ncdhhs.gov/reports/annual-reports-and-tables>. Although the NCMO handled fewer calls than estimated by advocates based on other states, they opened more cases. However, the NCMO provided more substantive services than the BSS in the states upon which the estimates were based. See Letter from Elizabeth Edwards, *supra* note 13 (discussing the need for the BSS to be properly resourced and based on other state programs, a North Carolina BSS could expect to receive about 11,500-15,000 requests for assistance with estimates for call numbers varying far more; demand would also likely vary on outreach and how helpful enrollees found the program).

¹⁶ H.B. 372, Gen. Assemb. N.C., Sess. 2015, 2015 N.C. Sess. Laws 2015-245 (N.C. 2015), <https://www.ncleg.gov/enactedlegislation/sessionlaws/html/2015-2016/sl2015-245.html> (setting forth the state reasons for the managed care transformation and the parameters for the Medicaid agency for designing the transformation) [hereinafter H.B. 372].

¹⁷ See, e.g., Adam Searing, Ctr. Children & Families, *Why Is North Carolina Getting Rid of Medicaid Managed Care Plan that Saves State Money?* (Sept. 2, 2015), <https://ccf.georgetown.edu/2015/09/02/nc-state-auditor-north-carolinas-provider-driven-nonprofit-managed-care-program-saves-money-improves-care-state-getting-rid/>; James M. Verdier et al., Ctr. for Health Care Strategies, *Enhanced Primary Care Case Management*

Programs in Medicaid: Issues and Options for States 29-30, 41 (Sept. 2009), https://www.chcs.org/media/EPCCM_Full_Report.pdf.

¹⁸ H.B. 372, *supra* note 16.

¹⁹ See N.C. Dep't Health & Human Servs., Policy Papers, <https://medicaid.ncdhhs.gov/meetingsnotices/proposed-program-design/policy-papers> (listing policy guidance and papers, including archived policy papers for public comment during the transformation design phase); see generally Mandy K. Cohen, *North Carolina's Transformation to Medicaid Managed Care*, N.C. MED. J. 80(5) (Sept. 1, 2019), <https://ncmedicaljournal.com/article/55091-north-carolina-s-transformation-to-medicaid-managed-care> (describing the Department's approach to managed care design in the early phases); N.C. Dep't Health & Human Servs., Proposed Program Design, <https://medicaid.ncdhhs.gov/meetings-notices/proposed-program-design>; N.C. Dep't Health & Human Servs., Transformation, <https://medicaid.ncdhhs.gov/transformation>.

²⁰ See generally North Carolina Medicaid Reform Demonstration, Ctrs. Medicare & Medicaid Servs., <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/82766> (listing the original approval in 2018 and most recent extension in late 2024). The demonstration approved in 2018 included innovative components to achieve the stated goals, like Health Opportunities to address a wider array of social-related health needs. *Id.*

²¹ N.C. Dep't Health & Human Servs., North Carolina Medicaid and NC Health Choice, Annual Report for State Fiscal Year 2022 (July 1, 2021 – June 30, 2022), at 39, <https://medicaid.ncdhhs.gov/ncmedicaid-annual-report-sfy2022/download?attachment>.

²² See, e.g., N.C. Dep't Health & Human Servs., July 1 Launch of Behavioral Health and Intellectual/Developmental Disabilities Tailored Plans (Apr. 10, 2024), <https://www.ncdhhs.gov/news/press-releases/2024/04/10/july-1-launch-behavioral-health-and-intellectualdevelopmental-disabilities-tailored-plans>; N.C. Dep't Health & Human Servs., North Carolina Launches Children and Families Specialty Health Plan (Dec. 1, 2025), <https://www.ncdhhs.gov/news/press-releases/2025/12/01/north-carolina-launches-children-and-families-specialty-health-plan>; N.C. Dep't Health & Human Servs., Children and Families Specialty Plan, <https://medicaid.ncdhhs.gov/beneficiaries/children-and-families-specialty-plan>. Tailored Plans provide physical health, behavioral health, I/DD, TBI, long-term services and supports (LTSS), and pharmacy needs for Medicaid beneficiaries with mental illness (SMI), serious emotional disturbance (SED), severe substance use disorders (SUDs), and intellectual and developmental disabilities (I/DD). Tailored Plans also provide services under 1915(c) Innovations, TBI waiver services, and 1915(i) services—home and community-based service. Previously, many of the Tailored Plan behavioral health services were under managed care services, but the transformation moved physical health services to managed care as well. See generally N.C. Dep't Health & Human Servs., Behavioral Health and Intellectual/Developmental Disabilities Tailored Plans, <https://medicaid.ncdhhs.gov/tailored-plans>.

²³ N.C. Dep't Health & Human Servs., *Over 600,000 North Carolinians Enrolled in Medicaid Expansion* (Dec. 16, 2024), <https://www.ncdhhs.gov/news/press-releases/2024/12/16/over-600000-north-carolinians-enrolled-medicaid-expansion>.

²⁴ N.C. Dep't Health & Human Servs., N.C. Medicaid 2019 Provider Playbook, Fact Sheet #1, Medicaid Transformation Overview (2019), <https://medicaid.ncdhhs.gov/provider-factsheet1-medicaidtransformation-overview-final/download>.

²⁵ See, e.g., N.C. Dep't Health & Human Servs., Medicaid Managed Care Proposed Concept Paper, Beneficiaries in Medicaid Managed Care (Mar. 8, 2018), <https://medicaid.ncdhhs.gov/beneficiaries-medicaid-managed-care/download?attachment>; N.C. Dep't Health & Human Servs., Medicaid Managed Care Proposed Concept Paper, North Carolina's Vision for Long-Term Services and Supports under Managed Care (Apr. 5, 2018), <https://medicaid.ncdhhs.gov/north-carolinas-vision-long-term-services-and-supports-under-managed-care/download?attachment>; N.C. Dep't Health & Human Servs., Medicaid Managed Care Proposed Concept Paper, North Carolina's Care Management Strategy for Behavioral Health and Intellectual/Developmental Disability Tailored Plans (May 29, 2019), <https://medicaid.ncdhhs.gov/north-carolinas-care-management-strategy-behavioral-health-and-intellectualdevelopmental-disability/download?attachment>; see generally N.C. Dep't Health & Human Servs., Policy Papers, <https://medicaid.ncdhhs.gov/meetingsnotices/proposed-program-design/policy-papers> (archiving many of the managed care transformation policy papers).

²⁶ See, e.g., Communications from Nat'l Health Law Program & other N.C. Medicaid Advocates to N.C. Dep't Health & Human Servs. (2015 – present) regarding managed care design (on file with authors).

²⁷ See, e.g., Disability Rights N.C., Disability Rights NC Secures Changes to Innovations Waiver Administration (July 24, 2018), <https://disabilityrightsync.org/news/disability-rights-nc-secures-important-changes-to-how-mcos-administer-innovations-waiver-services/>; Nat'l Health Law Program, *McCartney v. Dempsey* (Apr. 7, 2008); <https://healthlaw.org/resource/mccartney-v-dempsey-united-states-district-court-eastern-district-of-north-carolina/>;

²⁸ See, e.g., N.C. Dep't Health & Human Servs., Beneficiaries in Medicaid Managed Care (Mar. 8, 2018), <https://medicaid.ncdhhs.gov/beneficiaries-medicaid-managed-care/download?attachment>. The Department published earlier papers on initial design and began the Section 1115 public comment process in 2016, during which advocates pushed for a robust, external ombuds program that would serve all managed care enrollees. See generally Archive of Policy Papers and Comments (on file with authors). This paper uses the term "the Department" to generally refer to the State Medicaid agency or the Department of Health & Human Services more generally in the function of designing and implementing managed care for the Medicaid program in North Carolina.

²⁹ State of N.C., Off. of the State Auditor, Dep't Health & Human Servs., Div. Health Benefits, Medicaid LME-MCO Contract Monitoring Performance Audit 10 (May 2019), <https://www.auditor.nc.gov/documents/reports/performance/per-2018-4445b-0/open> (identifying improvements needed in managed care oversight, including failure to evaluate beneficiary complaints and grievances); see also Rose Hoban, N.C. HEALTH NEWS, *Mental Health Agency Audit Finds Funds Spent on Cars, Travel, Parties – All Legal* (May 19, 2017), <https://www.northcarolinahealthnews.org/2017/05/19/mental-health-funds/> (reporting on state auditor's report regarding Cardinal Innovations, a North Carolina managed care entity for behavioral health, oversight by the State, and complaints from providers and beneficiaries).

³⁰ Beneficiaries in Managed Care (2018), *supra* note 28, at 15.

³¹ State of North Carolina, Dep't Health & Human Servs., RFI No. 30-180356, 4 (June 6, 2018), <https://www.ncdhhs.gov/medicaid-managed-care-ombudsman-program-rfi/open> [hereinafter RFI].

³² State of North Carolina, Dep't Health & Human Servs., Div. of Health Benefits, Ombudsman Services, Request for Proposal #30-190485-DHB (May 30, 2019), <https://www.ncdhhs.gov/request-proposal-nc-medicaid-ombudsman-services/open> [hereinafter RFP]; *see generally* N.C. Dep't Health & Human Servs., Request for Proposals (RFPs) and Requests for Information (RFIs), <https://medicaid.ncdhhs.gov/requests-proposals-rfps-and-requests-information-rfis> (listing the RFP for NC Medicaid Ombudsman Services along with addenda, the Department's response to questions and supplemental questions, revisions, and extensions).

³³ N.C. Dep't Health & Human Servs., *NCDHHS Awards Contract for Medicaid Managed Care Ombudsman Services* (Jan. 20, 2021), <https://www.ncdhhs.gov/news/press-releases/2021/01/20/ncdhhs-awards-contract-medicaid-managed-care-ombudsman-services>.

³⁴ N.C. Dep't Health & Human Servs., N.C. Medicaid and N.C. Health Choice, Annual Report for State Fiscal Year 2021 (July 1, 2020 – June 30, 2021), at 43 (Apr. 2022)

<https://medicaid.ncdhhs.gov/nc-medicaid-annual-report-sfy-2021/download?attachment>.

Duties began in March 2020 and within the first 90 days, the subset of staff handled 1,500 email and phone inquiries from hospitals, members, and Medicaid providers. They often triaged inquiries to subject matter experts, but handled 25 percent of inquiries at the point of contact. *Id.* *See also* Allen, *supra* note 14, at 2 (identifying one of the issues in the managed care transformation was providers failing to contract with all of the managed care plans).

³⁵ Many of these features and some of the specifics were required by the RFP, but they are summarized here with the NCMO approach readability. For more specifics on the requirements in the RFP, *see* RFP, *supra* note 32; *see generally* [Appendix A](#), Designing the NCMO: How Feedback Loops Informed Key Features.

³⁶ 42 C.F.R. § 438.71(d)(3) (restricting a BSS program from representing clients in a state fair hearing).

³⁷ RFP, *supra* note 32, at 71-75.

³⁸ NC Medicaid Ombudsman Process Review (on file with authors).

³⁹ Jones, *supra* note 2.

⁴⁰ NCTracks, NC Medicaid Ombudsman Program Transition (Dec. 31, 2025),

<https://www.nctracks.nc.gov/content/public/providers/provider-communications/2025-Announcements1/NC-Medicaid-Ombudsman-Program-Transition.html> (announcing the end of the contract with Legal Aid of North Carolina for the Ombuds Program as of December 31, 2025 and that the essential functions would continue with reduced services by NC DHHS' Division of Health Benefits).

⁴¹ *Id.*

⁴² 42 C.F.R. § 438.71(b).

⁴³ *Id.* § 438.71(d)(4).

⁴⁴ *Id.*

⁴⁵ Interview with NCMO staff (2025).

⁴⁶ *Id.*

⁴⁷ *Id.*; *see also* note 15, *supra* (citing annual reports that included the NCMO's case resolution rate of 98 percent for both years reported).

⁴⁸ *See, e.g.*, U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-24-106627, MEDICAID MANAGED CARE APPEALS AND GRIEVANCES 12 (2024), <https://www.gao.gov/assets/gao-24-106627.pdf> (finding that

effective BSS, including those that provide support to those receiving LTSS, may help resolve issues before an appeal is necessary and thus reduce the number of appeals a state must handle).

⁴⁹ Specific notice language available from authors.

⁵⁰ Like in North Carolina, these reports are not posted publicly.

⁵¹ Success Stories, *Independent Consumer Advocacy Network* (Last visited Mar. 24, 2026), <https://icannys.org/aboutican/successstories/>.

⁵² See note 25, *supra*.

⁵³ RFI, *supra* note 31, at 4.

⁵⁴ *Id.* at 4-5.

⁵⁵ *Id.*

⁵⁶ RFP, *supra* note 32, at 71-75.

⁵⁷ Data elements included the type of inquiry, notes, length of time before initial response, length of time before all questions were addressed and date closed; demographic information including Medicaid identifier, preferred language, date of birth, and county; and, if known, whether the individual received services through an MCO or fee-for-service. *Id.* at 54.

⁵⁸ *Id.* at 54-55.

⁵⁹ *Id.* at 55-56.

⁶⁰ *Id.* at 56-57.

⁶¹ *Id.* at 58-59.

⁶² *Id.* at 59.