Your Rights Under NC Medicaid Managed Care

A more comprehensive resource of Medicaid beneficiary rights in the Managed Care System

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The Right to an Adequate Network of Providers

Medicaid Managed Care Prepaid Health Plans (referred to as "Plans" throughout this Rights Guide) are allowed to have a "network," which is a limited group of doctors and other health care providers. Your Plan can generally tell you that you may only see doctors or clinicians in their network. There are only a few reasons you can go to a provider outside of your Plan's network (known as an "out-of-network provider"). When making its provider network, Plans cannot exclude providers unless the provider fails to meet quality standards or the provider does not accept the network payment rates. Quality standards are generally about the provider's ability to deliver good care.

The North Carolina Department of Health and Human Services (DHHS) has network requirements that Plans must meet. These requirements cover things like the maximum amount of time and distance members can be from a provider, wait times for scheduling appointments, and the minimum number of providers of a certain type within a geographic area like a county or region. These requirements vary by type of provider. More information about the network adequacy requirements can be found on this NC DHHS webpage.

Plans must contract with all "Essential Providers" located in their region to include them in their network, unless DHHS approves some other arrangement. Essential Providers include rural health centers, federally qualified health centers, local health departments, and free clinics. Plans must make and maintain a provider directory and update it at least monthly. The directory must include information including:

- The provider name,
- Geographic location,
- Provider specialty,
- Languages spoken by the provider office,
- If the provider is accepting new Members, and
- Accessibility of their office.

Plans may use telemedicine but cannot require individuals to use telemedicine.

Usually, your Plan needs to give prior approval (also known as "prior authorization") for you to receive care from a provider out of your Plan's network. However, for some services, Plans must approve out-of-network providers without a prior referral from your primary care physician. These services include:

- Emergencies and urgent care
- Family planning services
- Care needed while traveling out of state
- Services not available in-network in a timely manner
- Treatment provided during Transition of Care period

You also do not need prior approval from the Plan for these services:

- Items on above list,
- Children's screening,
- School based services,
- Health Department services,
- Women's health services, or
- Behavioral Health or Substance Abuse Assessment

Plans must allow you to get a second opinion from a network provider, or from an out-of-network provider if an in-network provider is not available.

As mentioned above, you have the right to receive out-of-network care if medically necessary services are not "promptly available" in your Plan's network. There are not strict timelines for what is considered promptly available, but the urgency of your need for the service is considered. Unless the service is one mentioned above that does not need approval for out-of-network care, you must request out-of-network care before you can get it. If that request is denied, you may appeal that denial. Your appeal rights are discussed beginning on page 11.

EXAMPLE

Belle has two daughters, 8-year old Elsa and 6-year old Anna. They are all enrolled in Medicaid, but Anna has complex medical conditions and receives services under the Community Alternatives Program for Children (CAP/C) waiver. Belle and Elsa are enrolled in the same managed care Plan, while Anna is in NC Medicaid Direct because she has CAP/C services. Belle needs to get a vision and hearing test for both Anna and Elsa. She does not need to get prior approval for these screenings because children's screenings do not require plan approval. However, for Elsa, Belle must find a provider in the Plan's network of providers. For Anna, Belle must simply find any Medicaid provider who offers the screening services.

Example Continued: In the same family as in the prior example, if Belle needs to see a specialist for her specific heart condition and the only provider in network is hours away from her home and cannot offer her an appointment within a reasonable time, Belle may want to request an out-of-network appointment from her Plan.

The Right to Access Needed Services

In general, in Medicaid Managed Care the coverage rules are the same as in NC Medicaid Direct (which is the name of traditional Medicaid in North Carolina, also known as fee-for-service Medicaid). This means that NC Medicaid Direct and each Plan should include the same type of services.

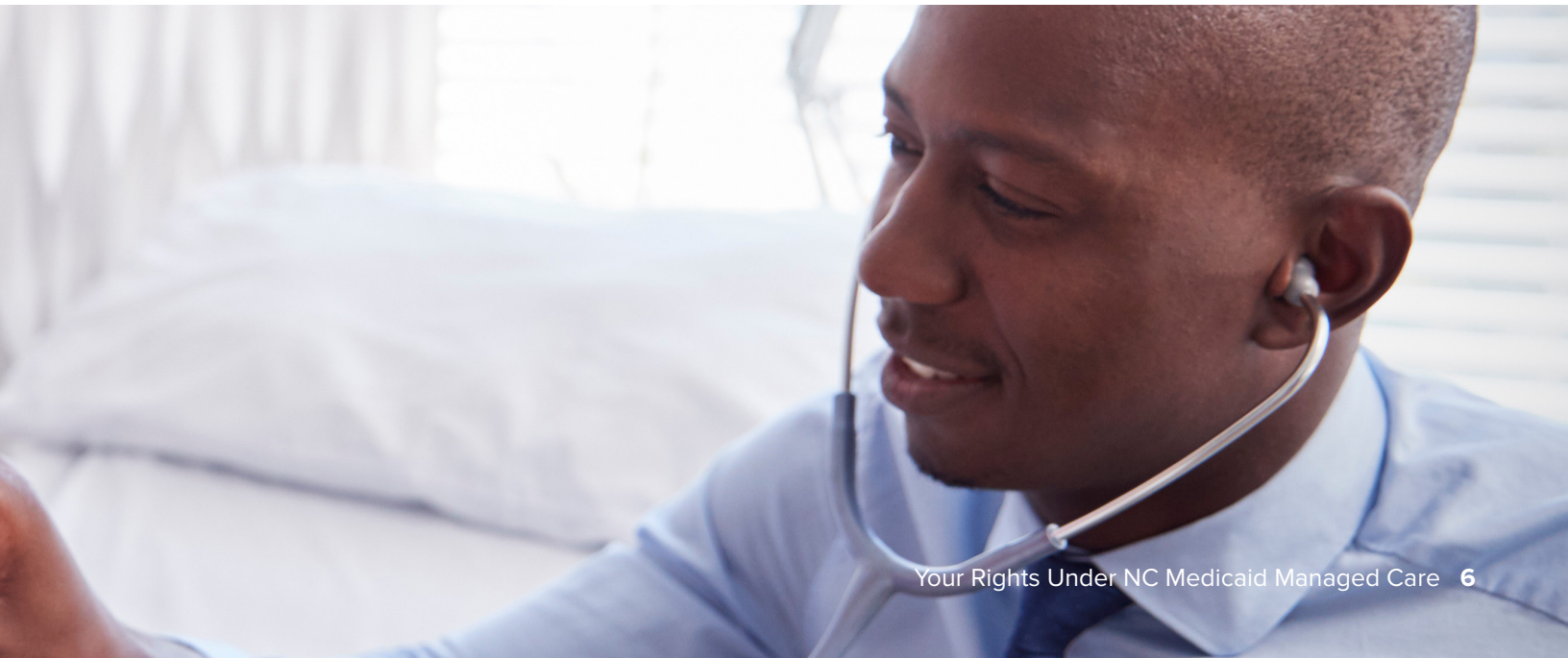
The following things should be the same regardless of whether you are in NC Medicaid Direct or a Plan:

- Cost sharing, or the amount you may be charged in co-pays or similar costs.
- The drug formulary, which is the list of prescription medications that can be prescribed.
- Access to non-emergency medical transportation (NEMT). In order to arrange transportation to an appointment, you should call to schedule transportation at least two days before the appointment. The contact information for scheduling transportation from the Plan is:
  - AmeriHealth Caritas: ModivCare (NEMT Broker): **833-498-2262**
  - Carolina Complete Health: ModivCare (NEMT Broker): **855-397-3601**
  - Healthy Blue: ModivCare (NEMT Broker): **855-397-3602**
  - UnitedHealthcare: ModivCare (NEMT Broker): **800-349-1855**
  - WellCare: MTM (NEMT Broker): **877-598-7602**

For NC Medicaid Direct and EBCI Tribal Option, contact your local DSS Office: ncdhhs.gov/localdss

If you are in a Plan, you also have:

- Access to a free Behavioral Health line, Member Services line, and Nurse's line;
- Certain protections to make sure your care is not interrupted if you are transitioning between plans or out of Medicaid Managed Care;
- Access to "in lieu of" or "value added" services, which are services a Plan can provide instead of or in addition to regular services if DHHS approves them. The Plan cannot make you use these services instead of the regular services they are replacing (or "in lieu of").
- Access to Care Management. If you qualify for care management:
    - Plans must help you get services you need.
    - Local care management is preferred, meaning you should get care management that is in your doctor's office, at home, or another community setting that is face to face.
    - Plans must provide transitional care management for people moving from one clinical setting to another, such as if you change providers because your old provider was not in the Plan's network.
    - Plans must assess for and assist in addressing Social Determinants of Health, including housing, food, transportation, and interpersonal safety. This means care management should do things like help with FNS (food stamp) applications, refer you to medical legal partnerships to help with legal problems, and have a housing specialist on staff.



The Right to Disenroll from Managed Care or Change Plans

Not all NC Medicaid members are required to enroll in a managed care Plan. While most individuals are in the "Mandatory" category, meaning they have to be enrolled in a managed care Plan, some individuals are "Exempt," meaning they have the option to enroll in a Plan. If they don't enroll, they will stay in NC Medicaid Direct. Other individuals are "Excluded," meaning they must stay in NC Medicaid Direct and cannot enroll in a Plan. For those who are required to enroll in a Plan, there are times and reasons why a person may change their Plan.

Who Can Disenroll from Medicaid Managed Care?

Whether you have to enroll in a Plan or you remain in NC Medicaid Direct depends on either (1) your diagnoses, disability, or being a member of certain group or (2) what services you use:

- Diagnoses, Disability, or Members of Certain Groups. You can enroll in Medicaid Direct if you are a:
  - Person with significant mental health needs, or diagnosis of severe substance use disorder, or traumatic brain injury (TBI);
  - Person with developmental disabilities, as defined in state law;
  - Person with serious mental health disability, as defined by the 2012 settlement agreement with DOJ, including those in the Community Living Initiative settlement; or
  - Child involved with the juvenile justice system or a child with Complex Needs.
- What services you use. You can remain in NC Medicaid Direct if you are a:
  - Person who has had 2 or more psychiatric hospitalizations or readmissions within the past 18 months; or
  - Person who has had 2 or more visits to the emergency department for psychiatric needs in the past 18 months; or
  - Person who was involuntarily treated within the past 18 months.

You can pick a Plan at the time of your Medicaid approval or at your renewal for Medicaid, which ususally happens once a year. You can change you Plan for any reason in the first 90 days after enrolling.

How to switch to a different Managed Care Plan or from Medicaid Managed Care to NC Medicaid Direct:

Changing Plans:
If you are enrolled in a Managed Care Plan, you can change to a different Plan at certain times or for certain reasons. You can pick a Plan at the time of your Medicaid approval or at your renewal for Medicaid, which usually happens once a year. You can change your Plan for any reason in the first 90 days after enrolling. If you want to change your plan more than 90 days after enrolling or your annual renewal, you need a special reason to change to a different Plan.

IMPORTANT

These special reasons include:

- You moved out of your Plan's service area;
- You have a family member in a different Plan;
- You cannot get all the related services, such as all of the services you need to treat a certain condition or all of the procedures related to a certain surgery, you need from providers in your Plan, and there is a risk in getting the services separately;
- A different Plan may be better for your complex medical conditions;
- Your Long-Term Services and Supports (LTSS) provider is not in your Plan;
- Your Plan does not cover a service you need for moral or religious reasons; or
- Other reasons (such as poor quality of care, lack of access to covered services, lack of access to providers in dealing with your health care needs).

Use this form to apply to change Plans: NC Medicaid Managed Care, Health Plan Change Request (ncmedicaidplans.gov) or call the Enrollment Broker at **833-870-5500**.

Moving from Medicaid Managed Care to NC Medicaid Direct

If you are "Exempt" from managed care, you may want to disenroll from a Plan and move to NC Medicaid Direct. You may want to disenroll from a Plan because you have had trouble getting your services or simply because you would rather have traditional Medicaid. Also, your circumstances may have changed and you may now be Exempt rather than Mandatory for managed care.

If you want to disenroll and think you are Exempt or Excluded from managed care, there are several options:

- You may file the form yourself (here in English and here in Spanish). You can submit the forms here.
- Your care coordinator or case manager may assist you in completing the form.
- Your provider may also request your disenrollment on a form to be used by providers, (here in English and here in Spanish). Your provider can also submit a Service Authorization Request (SAR) to help move you to NC Medicaid Direct faster.
- You may appeal to the Office of Administrative Hearings (OAH) within 30 days (see appeals for information on OAH hearings).
- You can contact the Enrollment Broker for assistance requesting to disenroll.

If you are considering disenrollment, you may find this DHHS fact sheet on NC Medicaid Direct process helpful.

Dealing with Problems when Changing Plans or Disenrolling

IMPORTANT

- If it is taking a long time to switch Plans or disenroll from Medicaid Managed Care, call the Enrollment Broker at **833-870-5500** to find out the status.
- If you receive a written denial of your request and would like to appeal, be sure to appeal within 30 days of the denial.
- If you have an urgent need for services that are only available in NC Medicaid Direct, you may ask for the change to happen immediately or retroactively, and your provider can submit a Service Authorization Request to help make this happen more quickly. In most cases, the change will happen the first day of the month after the request was approved.

The Plan you switched out of must transfer information necessary to ensure your medical care continues.

As a reminder of who is Exempt and Excluded from NC Managed Care, see **Who Can Disenroll from NC Managed Care?** above.

The Right to Disagree with a Plan - Grievances and Appeals

TIP

If you were denied a service or care you need but did not receive written notice, you can call the NC Medicaid Ombudsman at **877-201-3750** to find out if you can appeal. You can also call the NC Medicaid Ombudsman if you are not sure if you should appeal or submit a grievance. More information on the NC Medicaid Ombudsman is provided on page 31 below.

When health care is delivered through a Medicaid Managed Care Plan, there are specific processes that members of that Plan can use to disagree with what a Plan has done. There are two main processes: (1) Grievances and (2) Appeals.

For both grievances and appeals the Plan must give you reasonable assistance in completing the forms, filing a grievance or appeal, or filing for fair hearing. Reasonable assistance can include lots of things, such as providing auxiliary aids and services such as interpreters.

Grievances are what you file if you disagree with the quality of care or services or if a provider or Plan employee speaks to you improperly or treats you with disrespect. If you have a complaint about language access or accessibility, you can file a different type of complaint (see **The Right to Non-discriminatory Care: Language Access, Accessibility, and other Protections**). You can also file a grievance to disagree with the Plan's decision to allow themselves more time when you have asked for an expedited appeal (see below regarding requesting a faster or expedited appeal). Grievances are filed through the Plan's grievance system, usually through member services and follow this timeline:

- Within 5 calendar days the Plan acknowledges the grievance in writing.
- Within 30 calendar days the Plan tells you how they resolved the grievance.

If the grievance is related to the denial of an expedited appeal request (discussed further below), there are faster response times and other requirements.

TIP

Filing grievances to complain about problems in Medicaid Managed Care is important because Plans must track data and report on grievances. Data and reports on grievances are important because they help indicate Plan member satisfaction and ongoing issues.

Appeals

Appeals are what you file if you disagree with a Plan's decision about your services. This includes:

- Denial of requested services;
- Reduction or termination of authorized services;
- Denial of out-of-network services when care is not available in-network;
- Failure to provide services in a timely manner; and
- Failure of a Plan to meet the standard timelines for resolving grievances and appeals.

You also have the right to appeal when your request to change to a different Plan was denied or if you requested to disenroll from managed care and go to NC Medicaid Direct and were denied. Please refer to page 10 for information on that process.

You may have heard the right to appeal a decision that denies, reduces, or terminates Medicaid benefits called your "due process rights." This is because of the legal requirements that say a Medicaid beneficiary must have the right to contest a denial, reduction, or termination of benefits and be given the necessary information and opportunity to contest such a decision. This right to contest the decision and have a hearing is often called the right to due process.

EXAMPLE

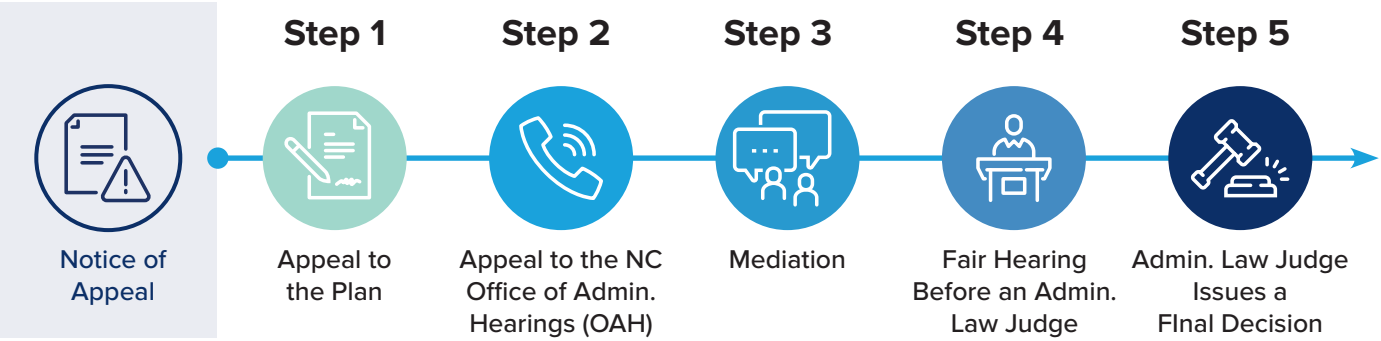
Back to our family of Belle and her children Elsa and Anna. Elsa has been diagnosed with developmental disabilities and Belle has been searching for providers for Elsa for services related to the developmental disabilities but has not been able to find any within their Plan's network of providers. She calls the Plan member services line to ask both about finding services and about disenrolling Elsa from the Plan. The Plan representative is rude to Belle and says she can see from her records that "people like Belle are always complaining about something." Belle is frustrated and ends the call without getting help or answers. Belle calls the Ombudsman program for assistance. They explain Belle's options for filing a grievance regarding the treatment by the member services representative. They also explain Belle's options for changing plans or how Belle may qualify, based on her disabilities, to disenroll from the Plan and move to NC Medicaid Direct. The Ombudsman program also asks Belle for more information about the search for a provider to determine if Belle may also be able to file an appeal for not being able to access services within a reasonable time period. The Plan acknowledges Belle's grievance about the member services representative within 5 days and sends her information on how they resolved the grievance within 30 days.

When to Appeal

It is important to pay atttention to deadlines in the Appeal Process.

If your Plan denies, reduces, or stops coverage for your care, the Plan must send you a denial letter by mail. This letter is called an Adverse Benefit Determination, and must explain the decision, provide specific reasons explaining why the decision was made, and explain how to appeal if you disagree with the decision. When a service you are currently getting is being reduced or terminated, the notice must be mailed at least 10 days before the change happens. When services are reduced or denied, you may choose to continue your services during the appeal process. There are important deadlines for filing the appeal and for requesting continued services.

The Appeal Process



Step 1 of Appeal – Reconsideration or Internal Review by the Plan.
You must first appeal the decision to the Plan through an internal review process with the Plan before you can file for a fair hearing at the NC Office of Administrative Hearings (OAH).

- Deadline to appeal is 60 days from the date of the notice.
- Appeal can be filed orally or in writing.
- You have the right to see a copy of the Plan's file about the decision and the right to offer new information.
- You have the right to be represented by an attorney or anyone else you choose, including providers. Providers may help you complete your appeal application, but providers may not file an appeal on your behalf. Providers are not allowed to request an Appeal Form unless you designate them to do so.
    - Your Plan is required to make their decision about the appeal within 30 days.
    - The Plan's decision on the internal review must be in writing and must include in the same mailing an Appeal Request Form which explains how to appeal to the NC Office of Administrative Hearings (OAH).

Step 1 of Appeal – Reconsideration or Internal Review by the Plan - CONTINUED

If you need a faster appeal:
You must first appeal the decision to the Plan through an internal review process with the Plan before you can file for a fair hearing at the NC Office of Administrative Hearings (OAH).

If the 30 day timeline for a decision on the Plan appeal is too long and would seriously endanger your life, physical or mental health, or ability to maintain, or regain maximum function, you can request a faster appeal process, known as an "expedited appeal."

- The Plan should issue an expedited appeal decision no longer than 72 hours after the Plan gets the appeal.
- The Plan may extend the timeline by 14 days if there is a need for additional information and the delay is in your interest.
- To request an expedited appeal, you ask the Plan. If the Plan denies your request for a faster appeal, you may file a grievance with the Plan.

Once you have the decision from an appeal, from either the standard or expedited process, the next step is appealing to the NC Office of Administrative Hearings (OAH).

EXAMPLE

Elsa has an accident on the playground. She is rushed to the ER and the doctors treat a broken leg. The orthopedic doctors who treat Elsa submit to the Plan a request for prior approval for 6 weekly sessions of physical therapy after the cast is removed. Weeks later but before the services are to start, Belle gets a letter saying the Plan will only approve 3 weekly sessions of physical therapy. Belle files an appeal and asks for it to be expedited because delaying services may seriously hurt Elsa's ability to regain the best function of her leg.

Step 2 of Appeal – Appeal to NC Office of Administrative Hearings (OAH)

- If you want to appeal the Plan decision to OAH, you must file the appeal within 120 days of your Plan's decision.
- OAH hearings are also called "fair hearings."
- You can request a fair hearing by calling **984-236-1850** or by faxing a written request to **984-236-1871**. The OAH website has information about the Medicaid appeals process at **oah.nc.gov/hearings-division/medicaid-recipient-appeals**.
- After requesting appeal, you may attend informal mediation with the Plan to try to resolve the dispute.

Step 3 of Appeal: Mediation

Mediation is an informal process where a mediator who does not work for Medicaid or the plan guides both parties through a discussion to see if the parties can agree on a way to solve the disagreement - in other words, to reach a settlement. You do not have to participate in mediation, but it may be a way to get what you need from the appeal.

THINGS TO KNOW

Things to Know About Mediation:

- New information or evidence may be raised during mediation.
- Mediations are usually held by telephone.
- A settlement could result in the Plan reversing or modifying their decision, or it could result in the Plan agreeing to postpone the appeal so it can review more information before deciding.
- There is no requirement to reach an agreement at mediation. Also neither statements or things either party reveals or admits, nor settlement offers discussed at mediation are confidential and cannot be used at the hearing by either side.
- Even if no agreement is reached, mediation may help you because it:
    - Allows the parties to negotiate without fear that any statements would be later used against them;
    - Allows the parties to "brainstorm" other services that can meet the same need;
    - Allows you to learn more about the basis for the denial or reduction and what the Plan will argue at a hearing.

You are not required to mediate, but if you agree and fail to participate (without having "good cause"), your appeal will be dismissed. Your appeal will **NOT** be dismissed if you decline mediation.

If mediation does not end in an agreement or you decide not to go to mediation, a formal hearing is scheduled with Administrative Law Judge (ALJ) at OAH. The ALJ is an impartial decision maker. In other words, the ALJ is not on your side or that of the Plan or Medicaid agency but is supposed to weigh the facts and other evidence with the law to come to a decision.

Step 4 of Appeal – Fair Hearing of Appeal before the ALJ at OAH

For the fair hearing, you have the right to:

- Receive a free copy of the information used by the Plan to make its decision. This is known as the Plan's file.
    - Be represented by an attorney or anyone else, including non-attorneys such as relatives or friends. Unlike criminal hearings, you do not have a right to a free attorney, but you may hire one if you would like. Legal services organizations like Legal Aid of NC or Disability Rights NC may be able to represent you in a fair hearing regarding your Medicaid services. See page 19 for contact information for these organizations.

Information about what happens at fair hearings:

- The fair hearing is a time for you to present information about why you qualify for the services you were denied.
- You can also ask the Medicaid representatives questions, such as why the services were denied, what information they based their decision on, and whether they considered other information that may indicate you qualify for the services.
    - Asking the Medicaid representatives questions is referred to as "cross-examining" them. This term simply means they are not witnesses you have asked to support your claims, but they are witnesses defending the decision of the Plan (or Medicaid agency).
- You may present your arguments/evidence orally to the ALJ.
    - For example, if appealing a reduction in services you may tell the ALJ why the amount of services you were given does not meet your needs, how your life is impacted by the lack of services, or what you cannot do because you do not have the services. The information given to the ALJ should be related to the criteria, often referred to as the clinical coverage policy, for when a service is authorized.
- You may also give the ALJ documents supporting your appeal, such as a letter from your provider explaining why you qualify for the services or your previous plan of care if that shows why you qualify for the service. The appeal is your chance to show you meet the criteria for the service and need the amount or duration of the service.

Step 5 of Appeal – The ALJ Issues a Written Decision

The decision must be sound and detailed, and the evidence the ALJ relies upon must be shared in the hearing.

For more information on appeals, see Medicaid Appeals Involving LME/MCOs - Disability Rights North Carolina (disabilityrightsnc.org), and the OAH website on Medicaid Appeals. While the NC Medicaid Ombudsman cannot represent you in an appeal, they can provide information about the appeal vs. grievance process, can work with you to try to resolve your concerns informally, and can help connect you to a legal services organization if your issue is not resolved.

Other Protections

In addition to filing an appeal, there are other due process protections for members regarding their right to disagree with the denial or reduction of services. For example, a plan may contact you or your provider to obtain information needed to decide a current request for services. However, the plan may not discourage the provider from submitting a request for needed services. There are important protections in NC that limit a Plan's ability to discourage or dissuade you or your provider from requesting services you need. There are also important protections for children under age 21 in Medicaid. These protections are often referred to as EPSDT protections or services because the part of the Medicaid Act they come from refers to Early and Periodic, Screening, Diagnostic and Treatment (EPSDT). Simplified, EPSDT generally requires that children get access to the Medicaid services they need even if there are limits on those services for adults or a Plan usually limits those services for kids. If the service is medically necessary for the child to correct or help address their condition and the treatment is not experimental, the child should receive the service. For more on EPSDT, NC DHHS has a website explaining EPSDT and the federal Centers for Medicare & Medicaid Services has a longer coverage guide available.

EXAMPLE

In the earlier example of Elsa breaking her leg and the Plan denying six weekly treatments, EPSDT helps Elsa. Even if the Plan typically only covers three weekly services for adults, because Elsa is a child and has EPSDT protections, if the six weekly sessions are medically necessary to heal her leg and correct her gait, she should get the six weekly sessions.

The Right to Non-Discriminatory Care: Language Access, Accessibility and Other Protections

All NC Medicaid Beneficiaries are protected from discrimination based on race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex, gender identity or expression, or sexual orientation. NC Medicaid does not exclude people or treat them differently because of any of these characteristics. There are several ways to file complaints about discrimination you've experienced. Which type of complaint you file may depend on who discriminated against you, and what trait the discrimination was based on.

If you have experienced discrimination by your Plan you can file a complaint as described below. You can also file an internal complaint with the Plan, usually through the grievance process. Remember, if you were treated rudely but do not think it was discriminatory, you may want to file a grievance (see **When to Appeal** above). If you are confused about where to file a complaint, the NC Medicaid Ombudsman may be able to help you understand the different options.

Language Access

Each Plan must provide Language Assistance Services. You have the right to get information in your preferred language for free. Plans must also make sure that all contact with you or your authorized representative is "culturally competent," which meets your needs based on your background and cultural experience. Plans must respect the method of communication you request, including requests for sign language interpreters, and Plans must ensure that this communication occurs in a timely manner. Written material must be in a language and format that is easily understood.

The NC Medicaid Ombudsman offers services in both English and Spanish and can accommodate other languages through language assistance services at **877-201-3750**.

If you believe you or someone else was treated unfairly because of that person's ability to speak English, you can file a complaint with the U.S. Office of Civil Rights (contact information below). If such treatment occurred through a NC County Department of Social Services a complaint can be filed through this form: https://www.ncdhhs.gov/media/7956/download. You must file this DSS-related form within 180 days of the date you or someone else was treated unfairly. The U.S Office of Civil Rights may have different timelines for filing a complaint.

Accessibility and Disability Discrimination

ENC Medicaid beneficiaries with disabilities must be provided reasonable accommodations to access services they need. For example, if you are deaf or hard of hearing, auxiliary aids and services should be available to make sure communication with you is effective. If you believe Medicaid has discriminated against you because of your disability, you may file a complaint at:

DHHS ADA/RA Complaints
Office of Legal Affairs
2001 Mail Service Center
Raleigh, NC 27699-2001

The State calls this type of complaint a grievance, but keep in mind that this is a different type of grievance than what you would file with a Plan. You can file a grievance in person or by mail, fax, or email. You must file your complaint in writing within sixty (60) days of when you become aware of the alleged violation. If you have questions about how to file a grievance, you can contact the NC Medicaid Ombudsman at **877-201-3750**. More information on the NC Department of Health and Human Services Grievance Procedures can be found at ncdhhs.gov/media/8251/open.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Right. You can do this in several ways:

- electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf
- by phone at **1-800-368-1019** (TDD: **1-800-537-7697**), or
- by mail at:

U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 509F, HHH Building
Washington, DC 20201

Complaint forms are available at ncdhhs.gov/media/7957/download and more information can be found at hhs.gov/ocr/office/file/index.html.

Additionally, Plans cannot discriminate against you if you:

- Live or receive health care in rural or underserved areas; or
- Experience income disparities.

Contact Information for Assistance

You have the right to get free advice over the phone from the NC Medicaid Enrollment Broker at **833-870-5500**. The Enrollment Broker can help you understand whether you have to enroll in a Plan and help you decide which Plan is the best choice for you and your family.

You also have the right for more information and help from the NC Medicaid Ombudsman. You can call them at **877-201-3750**, Monday through Friday, 8 a.m.–5 p.m. except state holidays. You can also email them at info@ncmedicaidombudsman.org and learn more at ncmedicaidombudsman.org.

If you would like to ask for help with a Medicaid appeal, legal services organizations like Legal Aid of NC or Disability Rights NC may be able to represent you in a fair hearing regarding your Medicaid services. Please see their websites for more information on the types of services they provide as they may be limited to certain subjects or populations. You may also call these organizations: Legal Aid of NC (**866-219-5262**); Disability Rights NC (**877-235-4210**). For an issue regarding NC Medicaid Managed care, you may want to start by calling the NC Medicaid Ombudsman as they can provide you information about appeals and grievances and also make referrals to appropriate organizations.

If you need to apply to Medicaid, contact your local Department of Social Services (DSS). You can find contact information for your local DSS office here: ncdhhs.gov/divisions/social-services/local-dss-directory.