STATE OF NORTH CAROLINA		**THE OFFICE OF ADMINISTRATIVE HEARINGS**
COUNTY OF WAKE		**14 DHR 1500**
CAROLINA COMMUNITY SUPPORT SERVICES, INC.,	)	
Petitioner,	)	
v.	)	
ALLIANCE BEHAVIORAL HEALTHCARE, ***as legally authorized contractor of and agent for*** **N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES,**	)	
Respondent.	)	

FINAL DECISION

THIS MATTER came on for hearing before the undersigned, Donald W. Overby, Administrative Law Judge, on November 12 and 13 and December 2, 2014 in Raleigh, North Carolina.

APPEARANCES

For Petitioner Carolina Community Support Services, Inc., ("Petitioner" or "Carolina Community"):

Robert A. Leandro
Parker Poe Adams & Bernstein, LLP
301 Fayetteville Street, Suite 1400
Raleigh, North Carolina 27601

For Respondent Alliance Behavioral Healthcare, *as legally authorized contractor and agent for* the North Carolina Department of Health and Human Services ("Respondent" or "Alliance"):

Joseph T. Carruthers
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1076 West Fourth Street, Suite 100
Winston-Salem, North Carolina 27101

APPLICABLE LAW

The laws and regulations applicable to this contested case are N.C. Gen. Stat. Chapter 108C, Article 3 of N.C. Gen. Stat. Chapter 150B, and 42 C.F.R. § 438.214.

BURDEN OF PROOF

Under N.C. Gen. Stat. § 108C-12(d), Respondent Alliance Behavioral Healthcare has the burden of proof as to the adverse determinations at issue in this contested case.

ISSUES

Petitioner Carolina Community contends the issue to be resolved in this case is whether Respondent Alliance, acting as the legally authorized contractor of and agent for the N.C. Department of Health and Human Services, failed to act as required by law or rule, exceeded its authority, acted erroneously, failed to use proper procedure, or acted arbitrarily or capriciously when it terminated Carolina Community's participation in the Medicaid Community Support Team, Intensive In-Home, and Substance Abuse Intensive Outpatient programs.

Respondent Alliance contends the issues to be resolved at the hearing are whether Alliance reasonably exercised its discretion in assigning scores in the interview step of the RFP process; whether Alliance reasonably exercised its discretion in deciding not to offer a contract for RFP services to Carolina Community; whether Alliance has the right to determine which providers will be in its network; and whether the maximum relief for Petitioner that is possible under N.C. law would be to allow Petitioner to provide RFP services through but not beyond December 31, 2014.

ADMITTED EXHIBITS

Petitioner's Exhibits 1–5, 7, 8, 10–13, 16, 19–21, and 27–31 were allowed into evidence. These exhibits are:

1. Carolina Community RFP Review Summary
2. Alliance RFP Interview Questions with Written Summaries of Responses
3. Contract Between NC Department of Health and Human Services and Alliance
4. Contract Between the NC Department of Health and Human Services, Division of Medical Assistance and Alliance
5. Carolina Community Provider Interview Sign-In Sheet
7. Carolina Community Gold Star Monitoring Results
8. Alliance RFP Desk Review Scoring Tool for Carolina Community
10. Alliance Request for Proposal, Community Support Team
11. Alliance Request for Proposal, Intensive In-Home Services
12. Alliance Power Point Presentation for Alliance's RFPs Committee Training, November 15, 2013
13. Alliance RFP Selection Summary
16. Alliance Behavioral Healthcare Provider Operations Manual
19. Carolina Community Support Intensive In-Home RFP Response
20. Carolina Community Support SAIOP RFP Response
21. Carolina Community Support Team RFP Response
27. Alliance Operational Procedure #6023 – Request for Information/Request for Proposal (Rev. 8/26/13)

28. Alliance Operational Procedure #6012 – Provider Network Capacity and Network Development (Rev. 9/15/14)
29. NCDHHS Provider CABHA website, "CABHAs: Critical Access Behavioral Health Agencies"
30. Email dated 5/24/14 from MINT Operations Manual to Lamar Marshall regarding MINT training membership listings
31. Alliance Notice of Non-Renewal of Contract to Carolina Community dated November 12, 3014

The Court took Judicial Notice of Petitioner's Exhibits 22, 23, and 26. These exhibits are:

22. 42 C.F.R. §438.214
23. N.C. Gen. Stat. §108C
26. Clinical Coverage Policy No. 8A (May 1, 2013)

Respondent's Exhibits 1–6, 7A, 8–28, 29A, 29B, and 29C were allowed into evidence. These exhibits are:

1. Alliance RFP for IIH
2. Alliance RFP for CST
3. Alliance RFP for SAIOP
4. Petitioner's Response to RFP for IIH
5. Petitioner's Response to RFP for CST
6. Petitioner's Response to RFP for SAIOP

7A. Desk Review Scoring Tool for Carolina Community for CST/SAIOP/IIH, reviewer Mary Ann Johnson (11/19/13)

8. Desk Review Scoring Tool for Carolina Community for CST, reviewer Alison Rieber (11/30/13)
9. 2013 Contract between Alliance and Carolina Community
10. Three-month extension to 2013 Contract between Alliance and Petitioner (through 3/31/14)
11. Non-renewal letter from Alliance to Carolina Community dated January 10, 2014
12. RFP Staff Training PowerPoint
13. Sign-in sheets for Carolina Community interview
14. Interview notes by Cathy Estes
15. Interview notes by Damali Alston
16. Interview notes by Alison Rieber
17. Interview notes by Mary Ann Johnson
18. Affidavit of Cathy Estes
19. Affidavit of Damali Alston
20. Affidavit of Alison Rieber
21. Affidavit of Carlyle Johnson, with exhibits
22. Provider RFP Review Summary
23. 2014 Contract with Petitioner for non-RFP services

24. 2014 Contract with B and D Behavioral for RFP services through June 30, 2014 (example of a contract given to providers who scored between 55 and 65 on interview)
25. 2014 Contract with Carolina Outreach for RFP services through December 31, 2014 (example of a contract given to providers who scored 65 and above on interview)
26. April 1, 2014 Contract Amendment with Petitioner following Preliminary Injunction Order
27. Contract between Alliance and DHHS
28. Alliance's Provider Manual
29A. Contract Amendment between Alliance and Evergreen Behavioral Management
29B. Contract Amendment between Alliance and Fidelity Community Support Group
29C. Contract Amendment between Alliance and Sunrise Clinical Associates

The Court took Judicial Notice of Respondent's Exhibits 30, 31, and 32. These exhibits are:

30. Order Denying Preliminary Injunction, *First Family Support Center v. Alliance*, 14 DHR 1737 (April 21, 2014)
31. Order Denying Petitioner's Motion for Preliminary Injunction, *Essential Supportive Services v. Alliance*, 13 DHR 20386 (January 22, 2014)
32. 42 C.F.R. §438.12

WITNESSES

Petitioner presented the testimony of:

1. Oswald Nwogbo, CEO of Carolina Community Support Services
2. Lamar Marshall, Director of Operations for Carolina Community Services

Respondent presented the testimony of:

1. William Carlyle Johnson, PhD, employee of Alliance Behavioral Healthcare
2. Cathy Estes, employee of Alliance Behavioral Healthcare
3. Alison Rieber, employee of Alliance Behavioral Healthcare
4. Mary Ann Johnson, previous employee of Alliance Behavioral Healthcare
5. Damali Alston, employee of Alliance Behavioral Healthcare

PROCEDURAL HISTORY

On February 27, 2014, Petitioner Carolina Community Support Services, Inc. ("Petitioner" or "Carolina Community") filed a Petition for Contested Case Hearing against Alliance Behavioral Healthcare ("Respondent" or "Alliance") acting as a contractor of the N.C. Department of Health and Human Services. Carolina Community contemporaneously filed a Motion for a Temporary Restraining Order and Stay of Contested Actions.

A Temporary Restraining Order was entered by the undersigned on March 7, 2014, and Petitioner's Motion for Stay was heard on March 28, 2014. By written Order dated April 11, 2014, the undersigned granted Petitioner's Motion for Stay and Preliminary Injunction. Said Order also memorialized the undersigned denial of Respondent's Motions to Dismiss for lack of jurisdiction made at the TRO hearing and again at the preliminary injunction hearing. The undersigned later denied Respondent's Motion to Reconsider Prior Motion to Dismiss on November 5, 2014.

This matter came on for full hearing before the undersigned over three days on November 12 and 13 and December 2, 2014.

BASED UPON careful consideration of the sworn testimony of the witnesses presented at the hearing, the documents and exhibits received and admitted into evidence, and the entire record in this proceeding the undersigned makes the following Findings of Fact and Conclusions of Law. In making the Findings of Fact, the Undersigned has weighed all the evidence and has assessed the credibility of the witnesses by taking into account the appropriate factors for judging credibility, including but not limited to, the demeanor of each witness, any interests, bias, or prejudice the witness may have, the opportunity of the witness to see, hear, know, or remember the facts or occurrences about which the witness testified, whether the testimony of the witness is reasonable, and whether the testimony is consistent with all other creditable evidence in the case.

FINDINGS OF FACT

The Parties

1. Carolina Community is a provider of mental health and behavioral health services with its principal place of business in Raleigh, North Carolina. Carolina Community assists consumers, including Medicaid recipients, at home, in school, and in the community in preventing, overcoming, and managing functional deficits caused by mental health issues and developmental delays.

2. Petitioner Carolina Community is located in Durham, North Carolina and serves Medicaid recipients in Durham, Wake, and Johnston County. (Nwogbo, Vol. 2, p. 511). Carolina Community was founded in 2009. (*Id*. at p. 510). Carolina Community is a provider of Medicaid Intensive In-Home ("IIH"), Community Support Team ("CST"), and Substance Abuse Intensive Outpatient ("SAIOP") services. (Nwogbo, Vol. 2, p. 560). These services are all Medicaid programs. (Johnson, Vol. 1, pp. 194–95).

3. Carolina Community is also a Critical Access Behavioral Health Agency ("CABHA") certified by the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services ("DMH") and the Division of Medical Assistance ("DMA"). (Nwogbo, Vol. 2, p. 510). Carolina Community must provide some combination of CST, IIH, or SAIOP services to continue to qualify as a CABHA. (Johnson, Vol. 1, p. 186-87).

4. Alliance is a multi-county area mental health, developmental disabilities, and substance abuse authority established pursuant to N.C. Gen. Stat. § 122C-115(c). Alliance is a local management entity ("LME") for publicly funded mental health, developmental disabilities, and substance abuse ("MH/DD/SA") services as defined in N.C. Gen. Stat. § 122C-3(20b). (Johnson, Vol. 1, p. 175). Alliance is not incorporated in North Carolina. (*Id.*).

5. Under federal and State law the North Carolina Department of Health and Human Services ("DHHS") is the single State agency authorized by the federal government to administer the Medicaid program. *See* 42 U.S.C. § 1396A(A)(5); N.C. Gen. Stat. § 108A-54. Under the law, DHHS is the only agency that is authorized to manage the Medicaid program, unless a waiver is granted by the federal government.

6. DHHS received approval from the federal government to operate a Medicaid waiver program under Sections 1915(b) and 1915(c) of the Social Security Act ("the 1915(b)/(c) Medicaid Program"). (Johnson, Vol. 1, p. 176; Pet. Exs. 3–4). As a part of the 1915(b)/(c) Medicaid Program, DHHS is permitted to enter into contracts with managed care organizations ("MCO") to operate a prepaid inpatient health plan ("PIHP") pursuant to 42 C.F.R. § 438.2.

7. In February 2013, Alliance entered into two contracts with DHHS allowing it to serve as a managed care organization ("MCO") under the 1915(b)/(c) waiver. Alliance manages Medicaid mental health, developmental disability, and substance abuse services provided in Cumberland, Durham, Johnston, and Wake Counties. (Pet. Ex. 16, p. 9). Alliance's duties include authorizing and paying for recipient services, contracting with providers, and monitoring providers for compliance with regulatory and quality standards. (Johnson, Vol. 1, pp. 28–29, 138).

Federal, State and Alliance Policy Requirements

8. The federal government has promulgated regulations that apply when states receive a waiver to operate Medicaid MCOs and PIHPs. One of these regulations is 42 CFR § 438.214(a) entitled, "*Provider Selection."* This regulation requires the State to ensure, through a contract, that each MCO/PIHP "implements written policies and procedures for selection and retention of providers." (Pet. Ex. 22) (Emphasis added).

9. 42 CFR § 438.214(e) requires MCO/PIHPs to "comply with any additional requirements established by the State." (*Id.*).

10. Alliance's witness, Carlyle Johnson, agreed that 42 CFR § 438.214 is applicable to Alliance because it operates as a PIHP pursuant a Medicaid waiver. (Johnson, Vol. 1, pp. 178–79).

11. In conformity with 42 CFR § 438.214, Alliance has executed two contracts with DHHS. These contracts require Alliance to create Provider Selection and Retention policies. (Pet. Exs. 3, 4). One of the contracts states that in determining whether CABHAs will remain in the MCO's network the MCO must consider the "performance of the agency as measured against identified indicators and benchmarks." (Pet. Ex. 4, p. 92, Attachment O, Sec. 4).

12. The contract also anticipates that Alliance may issue RFPs, but states that "if there is a competitive Request for Proposal, a scoring process will be developed to assess the provider's competencies specific to the requirements of the Request for Proposal, the service definition, and enrollment requirements as delineated above." (Pet. Ex. 4, p. 94, Attachment O).

13. Pursuant to federal law and the State contracts Alliance has developed provider selection and retention policies, which are included in the Alliance Provider Operations Manual. (Pet. Ex. 16, pp. 35–38; Johnson, Vol. 1, p. 180).

14. In instances where Alliance decides to use an RFP to select or retain providers, it has created an RFP Procedure that sets forth the process that Alliance will use in selecting providers. The purpose of these procedures "is to ensure that Alliance Behavioral Healthcare has a fair, uniform and consistent approach for establishing contracts with potential, new and current providers" (Pet. Ex. 27, p. 1).

The Alliance RFP

15. On September 30, 2013, Alliance announced that all current network providers off IIH, CST, and SAIOP would be required to respond to a Request for Proposal ("RFP") in order to

continue to provide services in the Alliance Network. (Pet. Ex. 12, p. 7). Only existing providers were allowed to submit a response and the RFP was closed to providers who were not currently operating in the Alliance network. (Johnson, Vol. 1, p. 28).

16. Alliance contends that the reasons for the RFPs included that Alliance had excess capacity in its network and had concerns about quality of care; however, Alliance had no expectation regarding the number of existing providers that would be retained as a part of the RFP process. (Johnson, Vol. 1, p. 168; Vol. 2, p. 292; Pet. Ex. 12, p. 7). Prior to implementing the RFP process, Alliance conducted no study to determine if there were too many providers in the network. Alliance had no data indicating the number of providers that are needed for these three services in order to serve the Medicaid recipients in Alliance's service area. (Johnson, Vol. 1, p. 168).

17. One of the reasons Alliance issued the RFP was concerns it had over the quality of care being provided. (Johnson, Vol. 1, p. 172-173). However, Alliance did no review of the quality of services that had actually been provided by the providers who submitted an RFP response. (*Id.*). Rhetorically, if Alliance was truly concerned about quality of care, there were many other more efficient options for dealing with those providing sub-standard care, including the state mandated Gold-Star Monitoring assessments, which had already been completed in part.

18. Alliance released a separate RFP for each of the services. However the contents of the RFPs were almost identical. (Johnson, Vol. 1, pp. 29–30; *compare* Res. Exs. 1–3). The RFP process consisted of four steps. Alliance's articulated end goal was the identification and selection of an appropriate number of providers who can provide high quality, evidence-based and effective services for consumers in Alliance's four-county catchment area.

19. The first step required meeting certain minimum requirements. If providers did not meet minimum requirements, they went no further in the RFP process. If providers met these minimum requirements, Alliance offered three-month contract extensions from January 1, 2013, to March 31, 2014. (Res. Ex. 1, p. 12; Res. Ex. 2, p. 13; Res. Ex. 3, pp. 12-13).

20. If a provider met the minimum requirements, the Selection Committee would next evaluate and score the written proposal (the "Desk Review"). Providers that met a certain score on the Desk Review would then be invited to participate in an interview. (Res. Ex. 1, p. 12; Res. Ex. 2, p. 13; Res. Ex. 3, pp. 12-13).

21. Carolina Community met the established minimum requirements and was offered a three-month contract. Carolina Community accepted and signed a contract with an ending date of March 31, 2014. (Respondent Exhibit 10). The three-month contracts offered by Alliance, including the one with Carolina Community, contained no right to renewal or extension.

22. The RFPs included a number of service preferences that may be considered by Alliance during the review. (Res. Exs. 1-3, p. 2). These preferences included:

- Demonstrated capacity to implement the requirements specified in the Scope of Work in this RFP;
- Have a solvent and financially viable organization with a history of financial stability that has sufficient financial and administrative resources to implement and operate the services specified in this RFP;
- Have a history of serving a monthly average of at least 6 per team in Intensive In-Home, 15 recipients for Community Support Team, and 15 recipients for SAIOP. Although caseload size is not a determining factor, organizations must demonstrate experience, financial viability, and the ability to provide the service in accordance with the service definition and the criteria in this RFP;

- History of submitting timely and complete requests for prior authorization that contain all administrative and clinical requirements (i.e. does not have an excessive number of administrative denials);
- Demonstrated ability to timely and successfully submit clean claims using the Alpha provider portal or 837s;
- Have a well-developed quality management program that monitors and improves access, quality, and efficiency of care;
- Have human resources and management support necessary to effectively recruit and retain clinical and administrative qualified professional staff.

(Res. Exs. 1–3, p. 2)

23. In addition to these preferences, the RFP "Scope of Work" Section of the RFPs states that:

- Clinical Staff must be proficient in Motivational Interviewing and must have received training for a MINT-Certified trainer;
- CST Staff are dedicated only to the CST program and not "shared" within the agency to staff other programs;
- Provider must offer outpatient services within the same county(ies) in which they provide the service;
- Provider must demonstrate that they have access to medication management and psychiatric services within the local community or using telepsychiatry through either a staff position or an established contract. There must be clear evidence of oversight/involvement by the CABHA Medical Director in the organization. If the Medical Director is a contract position, minimum hours contracted must be 10 hours per week;
- Provider must provide evidence they provide general health screening, partnership with physical health providers and integration of health services within model of care;
- Provider must demonstrate compliance with service definition requirements associated with staff training and ratios. Preference will be given to agencies that employ a fully licensed team lead.

(Res. Exs. 1–3, p. 5).

24. Other than the preferences contained on page 2 of the RFP and the bullets points listed above, the RFP contained no other guidance or standards for determining if a provider would be retained or terminated from participation. (Res. Exs. 1–3, p. 5).

25. The RFP response also requested that each RFP written response contain three references. The RFP indicates that references will be checked to "verify the accuracy of submitted materials and to ascertain the quality of past performance." (Res. Ex. 1, p. 11; Res. Exs. 2, 3, p. 12) Alliance did not use the references in any way during the review. (Johnson, Vol. 2, p. 338).

Alliance's Training of Staff that Conducted RFP Reviews

26. On November 5, 2013, Alliance held a training session for all staff members that would participate in the Desk Review or Interview process. (Johnson, Vol. 1, pp. 40–42; Pet. Ex. 12, p. 1).

27. As part of this training Alliance created a 14-page PowerPoint presentation. (Pet. Ex. 12; Johnson, Vol. 1, p. 216). The first 12 pages of the PowerPoint contain no information

directing reviewers on how to judge or score a provider's RFPs during the Desk Review or Interview. (Estes, Vol. 1, p. 105; Johnson, T. Vol. 1, pp. 217–20; Pet. Ex. 12).

28. Page 13 is the only page in the entire PowerPoint that contains any guidance on how the reviewers should assign scores during the Desk Review and Interview. Page 13 contains a Likert Rating Scale that ranges from 1 to 5. (Pet. Ex. 12, p. 13). The scale contains general descriptive terms for the 1–5 ratings. For example, a score of 1 is "unsatisfactory, unclear and incomplete, insufficient;" a score of 3 is "sufficient and satisfactory but some questions or concerns;" and a score of 5 is "exceptional model program, no questions remain." Page 13 contains no guidance on how these scores should be assigned and does not outline the criteria that should be considered when assigning these scores. (*Id.*).

29. Alliance testified that the PowerPoint and the RFP were the only guidance reviewers were given to determine how to score a provider's response during the Desk Review and Interview. (Johnson, Vol. 1, pp. 226-227; Alston, Vol. 2, p. 501).

30. The RFP contained no information or guidance to reviewers indicating how the Likert Scores of 1–5 should be assigned. (Res. Ex. 1–3). The only substantive guidance contained in the RFP are the preferences and the six Scope of Work requirements. (Res. Exs. 1–3, pp. 2, 5). There was no guidance instructing reviewers on how these preferences or Scope of Work requirements should affect the score awarded to the provider during the Desk Review or Interview.

31. Many of the preferences Alliance listed in the RFP were not considered in the review at all or were not considered by the interview panel when assigning scores to providers. For example, Alliance did not consider its preference for providers that demonstrate timely submission of clean claims during the review. (Johnson, Vol. 2, pp. 321–22). Some of the RFP preferences were only considered during the Desk Review while others were considered in both the Desk Review and the Interview. (*Id*. at pp. 326–327). There was no guidance given to the reviewers as to how to determine which preferences should be considered and what score should be assigned for meeting or not meeting these preferences. (Estes, Vol. 1, p. 105; Pet. Ex. 12; Res. Exs. 1–3).

32. When asked by the Court if the reviewers had been given guidance on how to score providers, Allison Rieber, one of the individuals that participated in both the Desk Review and the Interview of Carolina Community, stated – "there was not specific guidance." (Rieber, Vol. 2, p. 421). Similarly, Cathy Estes, another individual that participated in both the Desk Review and the Interview for Carolina Community, testified that the training never included what an answer should look like, or what the requirements were. (Estes, Vol. 1, pp. 105–106, 115).

33. Instead RFP reviewers were instructed to use their own experience and judgment when assigning scores. (Johnson, Vol. 1, p. 239). Ms. Estes admitted that this standard was subjective in nature. (Estes, Vol. 1, pp. 130, 151).

34. The lack of any standards led to many disparities over what information was relevant and responsive to the RFP and how that information should be scored. Reviewers trained through the exact same process and reviewing the exact same information scored responses very differently. In several instances a reviewer would determine a RFP response was inadequate and unsatisfactory while a different reviewer would find that same response good, strong and clear. (Pet. Ex. 8, Chart of Scores).

35. The lack of any standards allowed reviewers to substitute their own preferences when no such preference existed in the Alliance RFP. For example, Alliance admitted that a reviewer or interview panel might believe that the provider should provide certain information regarding HIPAA compliance while another interview panel might believe that providing

information regarding HIPAA compliance was unnecessary**.** (Rieber, Vol. 2, p. 423). Dr. Johnson testified that for CABHA medical directors the "preference is for psychiatrists." (Johnson, Vol. 1, p. 252). No such preference is expressed by Alliance in its RFPs. (Res. Exs. 1-3).

Carolina Community's RFP Review

36. The Alliance RFP Review Process consisted of three steps once a provider submitted its written proposal. (Res. Ex. 1, pp. 12–13; Johnson, Vol. 1, p. 32–34, 40). First, Alliance reviewed the written proposal to determine if the provider met minimum criteria. (Res. Ex. 1, p. 12; Johnson, Vol. 1, p. 32). All three of Carolina Community's RFP Responses passed the minimum criteria requirements and proceeded to the Desk Review. (Pet. Ex. 1, p. 3).

The RFP Desk Review

37. The second step of the RFP process consisted of a Desk Review of the provider's written RFP Response. (Johnson, Vol. 1, p. 33). At the Desk Review stage, several individuals were assigned to review and score specific sections of the providers' written responses, which were given different weights when the Desk Review Score was assigned. (Johnson, Vol. 1, pp. 218–219). The RFP sections scored by Alliance in the Desk Review included: the Executive Summary (5%); Organizational Background (10%); Clinical Programing and Response to Scope of Work (50%); Legal and Compliance Information (10%); Financial Information (20%); and Technological Capability (5%). (Pet. Ex. 12, p. 10; Res. Ex. 1 p. 13).

38. The review was conducted by various individuals employed by Alliance. For example, Alliance's legal department would review the legal and compliance information and Alliance's financial department would review the provider's financial information. (Johnson, Vol. 2, pp. 307–308). For the Clinical Programing Section of the Desk Review two individuals reviewed the written response and provided scores for each of seven categories. The scores for the seven categories were averaged to determine the Clinical Programing Score and Alliance used the highest average score as the provider's Clinical Programing score for the Desk Review. (Johnson, Vol. 1, p. 220).

39. If the provider scored 65% or higher on the Desk Review, the provider proceeded to the final stage of the RFP process. (Johnson, Vol. 1, pp. 33–34). At the Desk Review portion of the process, Carolina Community received scores of 73.1% (CST), 75.1% (IIH) and 69% (SAIOP) and thus Carolina Community qualified for an interview for all three services. (Pet. Ex. 1, p. 3).

40. The Clinical Scores for Carolina Community's Desk Review varied significantly. For Carolina Community's CST Desk Review, one reviewer, Allison Rieber, gave Carolina Community a score of 4 for Clinical Questions 2–4. (Pet. Ex. 8, Chart of Scores). A score of 4 indicates the reviewer believed that the answer was "Good, Strong, Well-Planned, Clear, and Reasonable." (Pet. Ex. 12, p. 13).

41. The other clinical reviewer, Cathy Estes, reviewing the exact same information gave Carolina Community a score of 2 for Clinical Question 2 and scores of 1 to Clinical Question 3–4. (Pet Ex. 8, Chart of Scores). A score of 1 denotes that the reviewer considered the response "Unsatisfactory, Unclear, Incomplete, and Insufficient." A score of 2 denotes that the response was "Minimal, Weak, Confusing, and Lacks some info." (Pet. Ex. 12, p. 13).

42. The wide variation in these scores means that for almost 50% of the clinical questions in the Carolina Community Desk Review, the reviewers had completely different understandings of what was required in the RFP. Ms. Estes explained that the difference between her and Ms. Rieber's scores were the result of the fact that she and Ms. Rieber had "different backgrounds and experiences." (Estes, Vol. 1, p. 151).

43. Ms. Estes' testimony reveals a very troubling aspect of Alliance's review because it shows that the review standards used by Alliance were not objective. Instead, reviewers were left to their own devices to determine how to score a provider's response based on their individual experience and backgrounds. As evidenced by the wide variation in the scores assigned by Ms. Rieber and Ms. Estes, it is clear to the Undersigned that these scores have little to no value because they are not based on whether the *provider's answer* complied with established criteria but instead were based on how the *reviewer's skills and experience* meshed with the provider's response.

44. Dr. Johnson could not recall the total number of reviewers that participated in the RFP process, but thought it was around ten. (Johnson, Vol. 2, 306). What is clear is that each reviewer that participated in the RFP process did not participate in every review. (Johnson, Vol. 1, p. 41; Vol. 2, pp. 314-315). This means that a provider's score was not based on objective and identifiable criteria but instead was almost entirely dependent on the subjective experience and expectation of each individual reviewer.

The RFP Interview Process

45. The final step of the RFP process was an interview (the "Interview"). At the Interview, a committee of individuals asked providers a series of nine scripted questions that corresponded to nine scoring categories. (Pet. Ex. 12). The individuals made up the provider interview panel varied from provider to provider. (Johnson, Vol. 1, p. 41; Vol. 2, pp. 314–15).

46. Scores at the Desk Review stage, whether good or bad, had no impact on the interview stage. Scores from the desk review were used only as a cut-off point to get to the next stage in the RFP process.

47. Both Ms. Estes and Ms. Rieber, participated in the Carolina Community Interview. (Res. Ex. 13). Despite the fact that Alliance had noted the discrepancy in Ms. Rieber's and Ms. Estes's Desk Review scores, Alliance undertook no efforts to discuss these discrepancies prior to the Interview and did not provide Ms. Rieber or Ms. Estes with additional guidance, training or feedback regarding how the responses should be scored during the interview stage. (Johnson, Vol. 1, pp. 224–25; Estes, Vol. 1, pp. 101–2).

48. A concern is that a provider's score could be affected by its oratorical skills and ability to communicate. The more skilled communicator could receive a higher score that may not be truly reflective of his agency as compared to others, and the converse is true as well.

49. At the interview stage, if a provider received a score 55% to 64% it received a six-month contract extension and a list of areas of improvement it should work on during that time period. (Johnson, Vol. 1, pp. 52–53). Providers that received a 65% or higher in the Interview received a one-year contract extension. (*Id.*, p. 56).

50. If a provider made it to the interview portion of the RFP process, the determination of whether that provider would be retained or terminated was made solely on the score assigned by the provider's interview panel. (Estes, Vol. 1, pp. 137–138; Johnson, Vol. 2, p. 314).

51. Alliance did no further review of the scores assigned by the different interview panels to determine if the interview scores were consistent. (Johnson, Vol. 2, pp. 330–31). It is problematic that no attempt was made to review or standardize these interview scores. Alliance had knowledge that its reviewers had different understandings regarding what was required by the RFP and yet did nothing to correct this problem.

Carolina Community Interview Scores

52. Carolina Community received scores of 52.2% (CST), 54.4% (IIH), and 54.4% (SAIOP) in the interview stage of the RFP. (Pet. Ex. 1, p. 3). If Carolina Community's score

would have been 0.1 higher (54.5%) it would have been retained as a provider of IIH and CST services. (Johnson, Vol. 1, pp. 52–53).

53. Carolina Community's final interview score was determined by the scores given by the interview panel in response to nine different questions that were asked during the interview. (Pet. Ex. 1 p. 3; Ex 2, p 1-3). As with the Desk Review, the interview panel used the Likert score of 1–5 for scoring these nine questions. (Estes, Vol. 1, pp. 96–97). The interview panel was given the same training and guidance on how to score the provider's interview responses set forth in the Findings of Fact above. (Johnson, Vol. 1, pp. 40–42).

54. As with the Desk Review Scores, at the interview a provider's score was not based on objective and identifiable criteria but instead was almost entirely dependent on the subjective experience and expectation of each individual reviewer. Merely averaging the divergent scores at any stage of the review does not address the fundamental problem of the subjective scoring. This process does not insure that all providers were being scored in a consistent and fair manner.

55. After Carolina Community was notified it would no longer be a provider, Alliance provided Carolina Community with written justification for the scores it received in the interview process. If Carolina Community received a score below 3 Alliance provided specific justifications for why that the score was assigned. (Pet. Ex. 1, p. 4–5). If a score of 3 or higher was assigned, Alliance did not provide any justification for the score. (*Id*.).

Interview Question 2 - Medication Management and Psychiatric Capacity

56. For the category of *Medication Management and Psychiatric Capacity*, Carolina Community was given a score of 2.5. (Pet. Ex. 1, p. 4). Alliance's justification for the 2.5 score was that Carolina Community only offers medication management for two hours a week on an every other week basis and that it also has a contract with AIMS to provide psychiatric assessments and medication management. (Pet. Ex. 1, p. 4; Johnson, Vol. 1, p. 235; M. Johnson, Vol. 2, pp. 442-443).

57. Based on the notes kept by Alliance's note taker and the interview panel members, when Carolina Community was asked about its medication management and psychiatric capacity it responded that its Medical Director provided medication management two hours a week on an every other week basis, and the Medical Director was "very accessible," making himself available at other times if the clients were not able to meet this time period. (Pet. Ex. 2, p. 1; M. Johnson Interview Notes, p. 5 C. Estes Interview Notes).

58. Alliance's low score justification makes no mention of the fact that Carolina Community told the panel its Medical Director was "very accessible" and is generally available to provide medication management if the scheduled times do not meet consumers' needs. (Pet. Ex. 1, p. 4; Nwogo, Vol. 2, p. 532). The RFP also creates no preference and sets forth no standard for the number of hours of medication management that should be available, so it is impossible to know why the reviewers believed this response was not sufficient. (Res. Exs. 1-3, pp. 2, 5).

59. In regard to Carolina Community's contract with AIMS, which is noted in the low score justification. The RFP states that "the provider must demonstrate that they have medication management and psychiatric services, either through a staff position, or an established contract." (Res. Exs. 1–3, p. 5). The RFP creates no preference that medication management or psychiatric services be provided by a staff position, only that the service be available either through a staff member or a contract. (*Id*.). Carolina Community's contract with AIMS cannot serve as a justification for the low score assigned for the *Medication Management and Psychiatric Capacity* category.

60. Alliance also justified its score of 2.5 for the *Medication Management and Psychiatric Capacity* category by stating that Carolina Community "does not provide medication management for any of their Wake consumers." (Pet. Ex. 1, p. 4). At the time of the interview, Carolina Community only provided services to one consumer residing in Wake County. (Nwogbo Vol. 2, p. 529; Marshall, Vol. 3, p. 576). Prior to receiving services from Carolina Community, this consumer had a relationship with a physician who provided medication management. (*Id.*).

61. Medicaid recipients are given provider choice and are allowed to determine whether they want to receive medication management from their existing physician or from their mental health provider. (Nwogdo, Vol. 2, pp. 529–530). Alliance agrees that this consumer had the right to continue to receive medication management from her physician. (Johnson, Vol. 1, pp. 249–250). In addition, Carolina Community made clear during the interview that it had the capability of providing medication management to this consumer. (Marshall, Vol. 3, p. 577).

62. The justifications for the score of 2.5 for the *Medication Management and Psychiatric Capacity* category are not supported by the RFP, any regulation or policy and are erroneous.

63. Carolina Community met all the requirements of the RFP for *Medication Management and Psychiatric Capacity* because it offers medication management and has a contract with AIMS to provide psychiatric assessments. Carolina Community's activities are consistent with the preferences and requirements set forth in the RFP.

Interview Question 3 – CABHA Medical Director and Clinical Oversight

64. Carolina Community received a score of 2 in the *CABHA Medical Director and Clinical Oversight* category. One of the justifications for the score of 2 was that the medical director's contract had been 8 hours a week, but was recently increased to 10 hours a week. (Pet. Ex. 1, p. 4).

65. Under State law, CABHA medical directors are not required to provide any specific number of hours of service per week. (Pet. Ex. 29; Estes, Vol. 1, p. 93). However, in the RFP, Alliance indicated a preference for medical directors that provided ten hours of service per week. (Res. Exs. 1–3, p. 2). Accordingly, prior to the submission of the RFP, Carolina Community adopted the preference set forth by Alliance in its RFP by extending the Medical Director to ten hours per week. (Nwogbo, Vol. 2, p. 531).

66. The fact that Carolina Community extended its Medical Director's hours to meet the newly issued preference of ten hours cannot reasonably serve as a justification for a low score. Since prior to the issuance of the RFP there was no specific requirement at all for the hours of the Medical Director, and once the RFP was issued, then Carolina Community met the preference, reason would dictate that is a positive and not a negative for consideration.

67. Another basis for the low score in the *CABHA Medical Director and Clinical Oversight* category was that the medical director is a family physician. (Pet. Ex. 1, p. 4). The RFP and the CABHA statute contains no restrictions on using a family physician as a medical director. The RFP also did not create a preference that the Medical Director be a psychiatrist. (Res. Exs. 1–3; Johnson, Vol. 2, p. 328). Dr. Johnson testified that any preference by the interview panel that the medical director not be a family physician was inappropriate and should not have been used by the reviewers. (*Id.*, p. 328). In this case, Carolina Community's medical director had significant psychiatric training. (Pet. Ex. 19, pp. 9–10).

68. Another justification for the low score assigned to the *Medical Director and Clinical Oversight* category was that the medical director did not review all of the CCAs (Comprehensive Clinical Assessments) but instead only reviewed the more complex cases. (Pet.

Ex. 1, p. 4). Under Clinical Coverage Policy 8A promulgated by DMA, CCAs do not need to be reviewed by a physician or a medical director. (Pet. Ex. 26, pp. 42, 53). There is no criteria or preference in the RFP relating to a medical director's review of CCAs (Res. Exs. 1–3).

69. The low score in the *Medical Director and Clinical Oversight* category also states that the medical director refers some of the more complex cases to Duke psychiatrists for their medication needs. (Pet. Ex. 1, p. 4). There is no preference or requirement in the RFP relating to a provider's decision to refer more complex cases to an academic medical center, like Duke University. (Res. Ex. 1–3, p. 2, 5). Alliance conceded that Duke University would have clinical staff with specific training which could be helpful to individuals with complex needs and that it would be appropriate to refer some complex cases to Duke University. (Estes, Vol. 1, p. 119).

70. Another justification for the low score in the *Medical Director and Clinical Oversight* category states that Carolina Community's medical director did not provide formal oversight and is available to staff via phone and email, but does not participate in regularly occurring meetings. Based on the evidence this statement is misleading. It is correct that Carolina Community's medical director makes himself available by phone and email, in excess of his 10 hour-a-week requirement. (Marshall, Vol. 3, p. 579). The evidence shows that the Medical Director also attends weekly meetings with Carolina Community's staff. (Marshall, Vol. 3, p. 579).

71. Based on the above Findings of Fact, a score of 2 for the *CABHA Medical Director and Clinical Oversight* criteria was erroneous because it was based on factually erroneous findings and standards, preferences, and requirements not contained in the RFP or any rule or regulation.

Interview Question 4 – Staffing for Services

72. Carolina Community received a score of 2 in the *Staffing for CST services* category and a score of 3 for the *Staff of IIH and SAIOP services category*. Alliance's justification for these scores states that all of the IIH team leads were provisionally licensed and that two of the three CST teams used a provisionally licensed team leader. (Pet. Ex. 1, p. 4).

73. Although the use of a fully-licensed team leader was listed as a preference in the RFP, Carlyle Johnson testified that meeting the clinical coverage policy requirements (*i.e.*, the use of provisionally licensed team leaders) should have resulted in a score of 3. (Johnson, Vol. 1, pp. 253-255). It is also inconsistent that Carolina Community received a score of 3 in IIH staffing even though all of its team leaders for that service are provisionally licensed, but Carolina Community received a score of 2 for its CST staffing, where only one of the team leaders for that service is provisionally licensed. (Pet. Ex. 1, p. 4).

74. The only other justification for the low score provided in the *Staffing* Services category is that Alliance had doubts, based on the written materials provided by Carolina Community, if all of Carolina Community's staff had Motivational Interview training ("MINT-Training") and for the ones trained in motivational interviewing, it did not appear that the training was done by MINT-certified trainers. (Pet. Ex. 1, p. 4).

75. Alliance testified that its concern came from the fact that some of the individuals listed as MINT-certified trainers in the Carolina Community RFP response were not listed on the MINT trainer website. Alliance did no research to determine why these trainers would not be listed on the website. (M. Johnson, Vol. 2, p. 441).

76. Alliance's "doubts" and thus low score was based on speculation and not founded in fact.

77. After receiving its score, Carolina Community called the MINT training service to inquire why the individuals who provided training to Carolina Community staff were no longer

listed as MINT-certified trainers. (Marshall, Vol. 3, pp. 585–586). Carolina Community was told that only those trainers that were currently providing MINT training were listed on the website. Certified individuals who no longer provided training would have been removed from the website. (*Id.*). This was confirmed by an email Carolina Community received from the MINT trainers' agency. (Pet. Ex. 30).

78. Alliance also had information that Carolina Community's staff was trained by MINT-certified trainers. Alliance conducted a Gold Star Monitoring of Carolina Community only a few months prior to the interview. (Rieber, Vol. 2, p. 404). During the Gold Star Monitoring, Alliance spent a significant amount of time on-site at Carolina Community reviewing its records, including staff qualifications. (*Id*. p. 397). During that time, Alliance reviewers determined that Carolina Community was in 100% compliance with staff training. (Pet. Ex. 7).

79. Alliance asked no question of Carolina Community at the interview regarding its use of MINT-certified trainers. (M. Johnson, Vol. 2, p. 440). If Alliance had a question regarding Carolina Community's use of MINT trainers, it should have asked a question and allowed Alliance to respond. Further, Alliance failed to review its own Gold Star findings which confirmed that Carolina Community's staff training was 100% compliant. (M. Johnson, Vol. 2, p. 439).

80. Based on the Findings of Facts above, Alliance's score in the *Staffing* category is not supported by the evidence and is erroneous.

Interview Question 5 – Evidenced Based Practices and Model Fidelity

81. Carolina Community received a score of 2 in the *Evidence Based Practices and Model Fidelity* category. (Pet. Ex. 1, p. 5). The RFP contains no criteria or guidance for judging this category other than stating that the providers should have implemented evidence-based practices. (Res. Exs. 1–3, p. 2, 5).

82. One of the justifications for the low score in this category was that Carolina Community stated it focused more on the clinical and less on data. (Pet. Ex. 1, p. 5). Alliance provided no evidence that it is inappropriate for a mental health provider to focus more on clinical services than data.

83. Alliance also used as a justification for its score the statement that Carolina Community gives clinicians written materials and the clinicians show evidence of using CBT by assigning clients homework. (Pet. Ex. 1, p. 5). This statement is accurate, however, incomplete. Carolina Community provided several other examples of how it implemented evidenced-based practices during its interview including, the use of surveys, monthly supervision meetings, chart review, and group observation (Pet. Ex. 2, p. 2). Carolina Community also informed Alliance that it has a contract with the Federal Prison System and that requires Carolina Community to be in 100% compliance with fidelity measures. (*Id*.).

84. Based on the above, the score of 2 in the *Evidence Based Practices and Model Fidelity Category* is not supported by the evidence and is erroneous.

Interview Question 9 – Quality Management

85. In the *Quality Management* category, Carolina Community received a score of 2. (Pet. Ex. 1, p. 5). In its justification for this score, Alliance states that it appeared that Carolina Community did not fully understand Quality Improvement ("QI") processes and measures and when questioned about QI projects, some of the projects were to get a new space and the fact that they were looking into obtaining an electronic medical records system. (*Id.*).

86. The interview questions relating to this category asked the provider to tell the panel about "complaints, grievances, and incidents, what they have learned through their review and what they were doing differently." (Pet. Ex. 2, p. 2). The interview notes also indicate that the

panel asked Carolina Community to tell it about its quality improvement projects. (Pet. Ex. 1, p. 5; Pet. Ex. 2, p. 2).

87. The justification for the low score in the category does not seem to relate to the question asked of Carolina Community regarding what it had learned through the complaint and grievance process. The score justification also implies that Carolina Community's projects of getting new space and obtaining an electronic medical records system do not qualify as a quality improvement project. (Pet. Ex. 1, p. 5).

88. Carolina Community provided significant testimony demonstrating how electronic medical records and a new space would improve the quality of services it provided. (Marshall, Vol. 3, pp. 590–599). Alliance's witnesses conceded that electronic medical records and obtaining a new space could better serve consumers and could improve the quality of services provided by Carolina Community. (Rieber, Vol. 2, pp. 417–418).

89. Based on the above Findings of Fact, the scores given to Carolina Community by Alliance in the interview portion of the RFP process are not supported by the justifications cited by Alliance. These justifications are erroneous, often unrelated to the RFP, do not demonstrate that Carolina Community was not conforming with any statute, regulation, or clinical coverage policy, and are arbitrary and capricious. Because Alliance's staff was not trained in the qualifications and requirements of the RFP, it appears that the interview panel simply substituted its own subjective judgment by assigning scores to Carolina Community that were not related to the RFP requirements and preferences.

Federal Requirements for Retention of Providers

90. As with all other providers in the Alliance network, Carolina Community was required to entered into a contract with Alliance to provide IIH, CST, and SAIOP services. These contracts are given to providers without any opportunity to negotiate or revise the contract. (Johnson, Vol. 2, p. 380).

91. Carolina Community's contract was in effect for a period between February 2013 and December 31, 2013. The contract of Carolina Community, and every other provider that met the minimum criteria, was extended through March 2014. (Res. Exs. 9, 29A, 29B, 29C).

92. Alliance contends that Alliance, at its sole discretion, can renew a contract or let it expire. (Johnson, Vol. 2, p. 368, 370; Res. Ex. 21, p. 6). If a contract expires the provider can no longer participate in that Medicaid program. Alliance contends in large part that the sole discretion is because it has a "closed network" which allows it to, in essence, do whatever it wants. "Closed Network" will be discussed further below.

93. The federal government has promulgated regulations that apply when states receive a waiver of federal Medicaid law to operate Medicaid MCOs and PIHPs. One of these regulations is 42 CFR § 438.214(a) entitled "*Provider Selection."* This regulation requires the State to ensure, through a contract, that each MCO/PIHP "implements written policies and procedures for selection and retention of providers." (Pet. Ex. 22) (Emphasis added). 42 CFR § 438.214(e) requires MCO/PIHPs to "comply with any additional requirements established by the State."

94. 42 CFR § 438.214 does not limit the selection and retention policies that can be implemented by an MCO/PIHP such as Alliance, but does require that these policies include at a minimum: (1) a process for credentialing and re-credentialing of providers who have signed contracts or participation agreements; (2) policies relating to nondiscrimination for providers that serve high-risk populations or costly treatment; and (3) a policy that the MCO/PHIP will exclude providers that are excluded by the federal health care program. *See* 42 CFR § 438.214.

95. Alliance's witness, Carlyle Johnson agreed that 42 CFR § 438.214 is applicable to Alliance because it operates as a PIHP as part of a Medicaid waiver program. (Johnson, Vol. 1, pp. 178-79). Alliance's position that it has absolute discretion to determine if it will renew a contract is contradicted by the existence of 42 CFR § 438.214, which requires Alliance to have selection and retention policies.

DHHS Contract Requirements Relating to Provider Retention

96. Pursuant to 42 CFR § 438.214, Alliance has executed two contracts with DHHS that contain Provider Selection and Retention requirements. First, Alliance executed a contract with the Department of Health and Human Services, Division of Mental Health ("DMH"). The DMH Contract requires Alliance to have written policies and procedures for "the determination of need, selection and retention of network providers." (Pet. Ex. 3, p. 23).

97. Alliance has also entered into a contract with the North Carolina Department of Health and Human Services, Division of Medical Assistance ("DMA"). The DMA Contract contains a similar provision requiring Alliance to create written policies and procedures for the selection and retention of network providers. (Pet. Ex. 4, pp. 32–33).

98. The DMA Contract further requires that "qualification for Providers shall be conducted in accordance with the procedures delineated in Attachment O." (*Id*.). Attachment O of the DMA Contract states that:

> Alliance shall maintain a provider network that provides culturally competent services. The provider network is composed of providers that demonstrate competency in past practices and consumer outcomes, ensure health and safety for consumers, and demonstrate ethical and responsible practices.

(Pet. Ex. 4, p. 92, Contract Attachment O).

99. Under the DMA Contract, CABHAs are considered agency-based providers. (Pet. Ex. 4, p. 92, Contract Attachment O). The DMA Contract states that "maintenance of agency-based providers [such as CABHAs] depends on performance of the agency as measured against identified indicators and benchmarks as well as Alliance's need as identified in an annual assessment." (Pet. Ex 4, p. 92, Attachment O, Sec. 4). Thus, under Attachment O, whether CABHA is allowed to continue to provide services must depend on the performance of the agency, specific measurable benchmarks and Alliances annual needs assessment.

100. As a CABHA in the Alliance network, Carolina Community must provide IIH, CST, or SAIOP in order to continue to be a CABHA. (Johnson, Vol. 1, pp. 186-187). Thus, Alliance's RFP decision determined whether Carolina Community would be maintained or terminated as an agency based Medicaid provider.

101. The DMA Contract also required Alliance's decision to be based on "identified indicators and benchmarks." (Ex.4, p. 4, p. 92, Attachment O, Sec. 4). Alliance did not base its decision on identified indicators and used no benchmarks during in the RFP process. Alliance violated the contract requirement based on the RFP review it conducted in this case.

102. Attachment O contemplates the use of an RFP, stating that "if there is a competitive Request for Proposal a scoring process will be developed to assess the provider's competencies specific to the requirements of the Request for Proposal, the service definition, and the enrollment requirements as delineated above." (Ex. 2, p. 94, Attachment O). Based on this language when an RFP is used, Alliance must use the requirements set forth in Attachment O of the DMA Contract when it makes its decision. (*Id*.). Based on the findings of facts above, Alliance did not use these factors in making its decision.

Alliance Policies and Procedures Relating to Provider Retention

103. In conformity with federal law and the State contracts, Alliance has developed provider selection and retention policies, which are included in the Alliance Provider Operations Manual. (Pet. Ex. 16, pp. 35–38; Johnson, Vol. 1, p. 180).

104. Section K of the Provider Operations Manual sets forth Alliance's Selection Criteria for initial participation in the Alliance network and is not applicable here because Carolina Community is already a provider in the Alliance network. (Pet. Ex. 16, p. 35).

105. Section L of the Provider Operations Manual sets forth Alliance's Retention Criteria (the "Retention Criteria"). Section L applies to decisions by Alliance relating to "contract renewal and reductions in network providers based on State and Federal laws, rules, regulations, DHHS contract requirements, the Network Development Plan, and the Alliance Selection and Retention Criteria." (Pet. Ex. 16, p. 36).

106. This policy applies to this contested case because Alliance was determining whether Carolina Community would be retained or terminated as a provider.

107. The Retention Criteria states that the Alliance Provider Network Management Committee ("PNMC") is responsible for making decisions about contract renewal and provider network reductions. (Pet. Ex. 16, p. 36). The evidence demonstrates that, in this case, the PNMC did not make the determination whether Carolina Community would be retained. (Johnson, Vol. 1, pp. 207–208).

108. Alliance's policy sets forth 17 criteria that it considers a "basis for non-renewal of contract(s)." (*Id*., pp. 16–17). The policy states that Alliance's decision will be based on, but not limited to these 17 criteria. These 17 criteria mostly relate to demonstrated actions by a provider, such as demonstrated compliance with policies and procedures, efforts to achieve evidence-based practices, and demonstrated consumer friendly service" (*Id*.). Based on the findings of facts above, Alliance did not use this criteria in the RFP.

109. The Retention Criteria also states that Alliance "has the right not to renew a contract with a Network Provider for any reason… at the sole discretion of Alliance." (Pet. Ex. 16. p. 37). Alliance sites this language from the policy as the basis for it having complete discretion to determine if a provider will be retained. (Res. Ex. 21, p. 6).

110. Alliance's policy that it has a right not to renew for any reason at its sole discretion is directly contradicted by federal law and the State contract requirements. It is illogical for the federal government and the State to require Alliance to have provider retention policies but allow one of those policies to be that Alliance need not follow any policy and has complete discretion to determine when it will retain a provider.

111. According to Dr. Johnson because Alliance operates a closed network, it has absolute discretion to determine with whom it wants to contract. (Johnson, Vol. 2, pp. 371-372). Alliance's contention of its position of authority as a "closed network" is demonstrated in part by the RFP which states that "Alliance reserves the right to reject any and all proposals for any reason, . . ." Further, Alliance has said that in exercise of its discretion, it simply does not want to contract with Carolina Community.

112. Dr. Johnson stated that as a closed network "Alliance is not required to admit any provider into the network once we have sufficient providers in the network." (Johnson, Vol. 1, p. 29). This case however, is not about admitting providers in the network, Carolina Community is already a provider in the network. Instead, this case is about whether Carolina Community would be retained in the network. There is no evidence that Alliance made a determination that it had "sufficient providers."

113. Alliance's argument that because it operates a closed network it has absolute discretion to determine if a provider will be retained is erroneous. When asked by the undersigned to define what is meant by a closed network, Alliance provide no response, other than it was likely defined in the DHHS Contracts. (Johnson, Vol. 2, pp. 371, 373). A review of the DHHS Contracts reveals that it contains no definition for a closed network. (Pet. Exs. 3, 4).

114. North Carolina statute defines the term "closed network" as:

> The network of providers that have contracted with a local management entity/managed care organization to furnish mental health, intellectual or developmental disabilities, and substance abuse services to enrollees.
> N.C. Gen. Stat. § 108D-1(2).

115. The statutory definition of "closed network" simply delineates those providers that have contracted with the LME-MCOs to furnish services to Medicaid enrollees. Under the statute, Carolina Community would qualify as a network provider within Alliance's closed network. Nothing in the definition of "closed network" indicates that the General Assembly provided MCOs absolute discretion to determine which existing providers can remain in the MCO's closed network once it is given a contract. Further, nothing in any North Carolina statute that references the term "closed network" delegates any discretion to Alliance to terminate an existing provider from its network. *See generally* Chapter 108D.

116. Alliance has provided no evidence that its operation of a "closed network" gives it absolute discretion to determine if it will retain a current network provider. Alliance has seemingly read something in the phrase "closed network" that does not exist in North Carolina law. Dr. Johnson and Alliance's contention that it has absolute discretion as to whom it will contract with because it operates a "closed network" simply is not true.

117. After stating that Alliance has absolute discretion, Alliance's Retention Criteria goes on to state that "in general Alliance will renew a Network Contract unless there is excess service capacity or the Network Provider meets any of the conditions outlined below." (*Id*., p. 37–38). All but one of these conditions relate to failures by the provider to meet certain requirements. None of the requirements serve as the basis for Carolina Community's termination. (*Id.*).

118. One of the conditions in Alliance's reasons for nonrenewal is if Alliance issues an RFP, RFI. (*Id*., p. 38). However, its policy does not state that if Alliance issues an RFP it can ignore its 17 provider retention factors when it creates the RFP review criteria. (*Id*.) Furthermore, Alliance's contract with DMA specifically states that if an RFP is used, Alliance must use the clinical coverage policies and the other requirements for retention contained in the DMA contract. (Pet. Ex. 4, p. 94, Attachment O).

Alliance's RFP Procedures

119. In instances where Alliance decides to use an RFP process, it has created an RFP Procedure that sets forth the process that Alliance will use in selecting providers. Alliance expects its staff to follow the RFP procedure when conducting an RFP review (Johnson, Vol. 1, p. 226). The purposes of these procedures "is to ensure that Alliance Behavioral Healthcare has a fair, uniform and consistent approach for establishing contracts with potential, new and current providers.." (Pet. Ex. 27, p. 1). Alliance's RFP Policy sets forth instances when exceptions to the procedure can be made. None of those exceptions apply in this contested case. (*Id*.).

120. The RFP Procedure requires Alliance to create and organize an RFP Selection Committee consisting of at least five members and reflecting relevant community stakeholder representation, including one or more, Community and Family Advisory Committee ("CFAC")

members and/or consumers representing the disability affected by the RFP. (Pet. Ex. 27, p. 2, Sec. 2.C.d). Alliance failed to follow this requirement. (Johnson, Vol. 2, p. 375).

121. The evidence shows that anyone that participated in the RFP Desk Review or interview was considered to be a member of the selection committee. This would have included the Legal Department, the Financial Department, the clinical reviewers, and all of the individuals that conducted any interviews or Desk Reviews for the 100 RFP applicants. (Johnson, Vol. 2, pp. 306–308).

122. The RFP Procedure also requires Alliance to develop a RFP Scoring Sheet based upon Bidder Criteria and Response Requirements outlined in the RFP template. (Pet. Ex. 27, p. 2, Sec. 2.C.f). The evidence demonstrates that Alliance did not follow this procedure. The RFP scoring sheet and guidance given to Alliance reviewers only outlined a scoring range of 1–5 but did not contain Bidder Criteria or Response Requirements. (Pet. Ex. 12, p. 13).

123. Alliance's RFP Procedure further requires the Project Leader to gather relevant agency compliance, complaint, and performance history and disseminate it to the Selection Committee to use as part of the evaluation/review process. (Pet. Ex. 27. p. 2 Sec. D.3). Alliance failed to do provide its interview panels with any compliance history. (Johnson, Vol. 2, p. 339). As a result, the interview panels had no way of knowing if the provider's response about their program was confirmed or contradicted by their compliance history.

124. In addition, the DMA Contract requires Alliance to base its decision on the demonstrated performance of the agency. (Pet. Ex. 4, p. 94, Attachment O). A provider's past compliance record would have provided valuable information to the interview panel about the demonstrated performance of the agency.

125. Carolina Community has had no compliance issues since it opened. (Nwogbo, Vol. 2, pp. 512-514). In addition, Alliance had conducted a thorough state-mandated review of Carolina Community called "Gold Star Monitoring" only a few months prior to the interview. (*Id.*).

126. Alliance's "Gold Star Monitoring" showed that Carolina Community received a very good score in this review. (Rieber, Vol. 2, p. 405). Carolina Community received a total score of 97% in this monitoring, with no score in any category below 95%. (Pet. Ex. 27). In contrast, over 40% of the reviewed providers received at least one score below 85% and required a plan of correction. (*Id*., p. 402). Ms. Rieber confirmed that the results from the Gold Star monitoring would constitute provider compliance history (Rieber, Vol. 2, p. 405). Under Alliance's RFP policy, the members of the Selection Committee should have been provided with information regarding Carolina Community's Gold Star Monitoring Score. (Pet. Ex. 27. p. 2 Sec. D.3).

127. If Alliance was truly concerned about quality of care the state mandated Gold Star Monitoring would have been a good place to start.

128. Alliance's RFP procedure also requires that the Selection Committee should be "convened to evaluate and review all responses." In this RFP review, the Selection Committee was not convened to evaluate and review all responses. (Johnson, Vol. 2, pp. 308, 310, 330–31). Instead, if the provider made it to the interview stage, the decision was made solely by the provider's interview panel. (Estes, Vol. 1, pp. 137-138; Johnson, Vol. 2, pp. 313-314).

129. Alliance failed to even review the basis for the interview panel's decision to determine if the panel had followed the RFP requirements or preferences. (Johnson, Vol. 2, pp. 330-31). In this case, if the Selection Committee would have been convened, it may have discovered that the Carolina Community interview panel had assigned scores based on criteria not found in the RFP, the clinical coverage policy, or any other policies or requirements.

Provider's Selected by the RFP Process

130. The providers selected through the RFP process were all allowed to continue to provide the services at issue and were given a contract that extended either through July or December 2014.

131. At the expiration of those contracts, the providers that were selected through the RFP process were all provided contract extension into 2015 if they continued to provide and bill Alliance for the service. (Johnson, Vol. 1, p. 258). The only way a contract would not have been extended into 2015 is if the provider had a serious compliance issue. (*Id*. p. 258).

132. Carolina Community has continued to provide services pursuant to a stay issued by this Court. Alliance has had no compliance issue during this time period (Nwogbo, Vol. 2, p. 512–14). Under the criteria set forth by Alliance, if Carolina Community would have been awarded a contract extension under the RFP, it would still be allowed to provide services in 2015.

133. Alliance has not cited any retention criteria that Carolina Community has violated since the stay was issued and has not provided any justification under its provider retention policies for why Carolina Community should not be a provider in its network.

134. Alliances contention that Carolina Community remained a credential, enrolled provider in the Alliance network without regard to the contract between Alliance and Carolina Community for CST, IIH, and SAIOP services is of no consequence. The administering of the RFP was specific to the provision of CST, IIH, and SAIOP services, and were necessary for Carolina Community to continue as a CABHA. The undersigned has consistently rejected in prior decisions such a narrow interpretation that obviates the harm in Alliance's decision merely because the Petitioner may be continuing to participate in other ways.

CONCLUSIONS OF LAW

To the extent that certain portions of the foregoing Findings of Fact constitute mixed issues of law and fact, such Findings of Fact shall be deemed incorporated herein as Conclusions of Law. Based upon the foregoing Findings of Fact, the undersigned makes the following Conclusions of Law:

1. As previously determined by this Court in response to Alliance's Motions to Dismiss, all parties are properly before the Office of Administrative Hearings, and this Court has jurisdiction of the parties and subject matter.

2. An ALJ need not make findings as to every fact which arises from the evidence and need only find those facts which are material to the settlement of the dispute. *Flanders v. Gabriel*, 110 N.C. App. 438, 440, 429 S.E.2d 611, 612 (1993).

3. Alliance contends that Carolina Community has no right to be a Medicaid provider and therefore this Court cannot find that Carolina Community's rights have been substantially violated by its decision. Alliance also argues that Carolina Community's rights are solely contractual in nature and once the contract expired, Carolina Community had no rights.

4. This contested case is not merely a contract case as Alliance contends. This contested case is about Alliance's almost total disregard for Federal and State laws and regulations and its own policies. Based on the evidence, the process for the RFP seems almost like it began on a whim—ostensibly to fix problems that had no basis in fact. The result was a flawed RFP in

which providers which might otherwise be comparable were treated differently, based in significant part on a subjective review.

5. Under numerous Supreme Court holdings, most notably the Court's holding in *Board of Regents v. Roth*, 408 U.S. 564 (1972) the right to due process under the law only arises when a person has a property or liberty interest at stake. S*ee also Bowens v. N.C. Dept. of Human Res.*, 710 F.2d 1015, 1018 (4th Cir. 1983).

6. In determining whether a property interest exists a Court must first determine that there is an entitlement to that property. *Cleveland Bd. of Educ. v. Loudermill*, 470 U.S. 532 (1985). Unlike liberty interests, property interests and entitlements are not created by the Constitution. Instead, property interests are created by federal or state law and can arise from statute, administrative regulations, or contract. *Bowens* 710 F.2d at 1018.

7. Under North Carolina case law, the Fourth Circuit Court of Appeals has determined that North Carolina Medicaid providers have a property interest in continued provider status. *Bowens*, 710 F.2d 1018. In *Bowens*, the Fourth Circuit recognized that North Carolina provider appeals process created a due process property interest in a Medicaid provider's continued provision of services, and could not be terminated "at the will of the state." The court determined that these safeguards, which included a hearing and standards for review, indicated that the provider's participation was not "terminable at will." *Id*. The court held that these safeguards created an entitlement for the provider, because it limits the grounds for his termination such that the contract was not terminable "at will" but only for cause, and that such cause was reviewable. The Fourth Circuit reached the same result in *Ram v. Heckler*, 792 F.2d 444 (4th Cir. 1986) two years later.

8. Since the Court's decision in *Bowen*, a North Carolina Medicaid provider's right to continued participation has been strengthened through the passage of Chapter 108C. Chapter 108C expressly creates a right for existing Medicaid providers to challenge a decision to terminate participation in the Medicaid program in the Office of Administrative Hearings. It also makes such reviews subject to the standards of Article 3 of the APA. Therefore, North Carolina law now contains a statutory process that confers an entitlement to Medicaid providers. Chapter 108C sets forth the procedure and substantive standards for which OAH is to operate and gives rise to the property right recognized in *Bowens* and *Ram*.

9. Under Chapter 108C, providers have a statutory expectation that a decision to terminate participation will not violate the standards of Article 3 of the APA. The enactment of Chapter 108C gives a providers a right to not be terminated in a manner that (1) violates the law; (2) is in excess of the Department's authority; (3) is erroneous; (4) is made without using proper procedures; or (5) is arbitrary and capricious. To conclude otherwise would nullify the General Assembly's will by disregarding the rights conferred on providers by Chapter 108C. This expectation cannot be diminished by a regulation promulgated by the DMA which states that provider's do not have a right to continued participation in the Medicaid program because under the analysis in *Bowen* the General Assembly created the property right through statutory enactment.

10. Alliance's contention that Carolina Community was not really terminated since they can participate in Alliance's network in ways other than providing CST, IIH, and SAIOP services, as well as continuing as a CABHA, is without merit. Carolina Community is being terminated from providing those services.

11. Alliance's contention that providers have no right to challenge Alliance's termination is therefore without merit given that the General Assembly has specifically given providers a right to contest a termination decision at OAH. If Alliance's position were correct, the appeals process provided by N.C. Gen. Stat. § 108C would be meaningless and would undermine the authority and power of legislative enactments. This is certainly not the case.

12. Based on all of the above, the undersigned finds that Chapter 108C provides Carolina Community the right to not be terminated in a manner that violates the standards of N.C. Gen. Stat. § 150B-23(a).

13. Alliance's contention that it operates a "closed network" and thus can terminate a provider at its sole discretion is also not supported by the law. Alliance can cite to no statute, regulation or contract provision that gives it such authority. The statutory definition of "closed network" simply delineates those providers that have contracted with the LME-MCOs to furnish services to Medicaid enrollees.

14. Alliance is relying on its own definition of "closed network" to exercise complete and sole control and discretion which is without foundation and/or any merit. Alliance's definition has no basis in law.

15. Nothing in the definition of "closed network" indicates that the General Assembly provided MCOs absolute discretion to determine which existing providers can remain in the MCO's closed network. Further, nothing in any North Carolina statute that references the term "closed network" delegates absolute discretion to Alliance to terminate an existing provider from its network.

16. Alliance's consistent position has been that this contested case should not be before OAH because the matter at hand is nothing more than a contract dispute. Alliance believes that it has absolute discretion to determine if a provider will be retained and that a provider's right to continued participation is automatically extinguished at the end of the provider's contract term. This positon is without merit.

17. Alliance's reliance on N.C. Gen. Stat. § 150B-23(a3) as a basis to narrow OAH's jurisdiction in this case is without merit. N.C. Gen. Stat. § 150B-23(a3) states:

> A Medicaid enrollee, or network provider authorized in writing to act on behalf of the enrollee, who appeals a notice of resolution issued by an LME/MCO under Chapter 108D of the General Statutes may commence a contested case under this Article in the same manner as any other petitioner. The case shall be conducted in the same manner as other contested cases under this Article. Solely and only for the purposes of contested cases commenced as Medicaid managed care enrollee

> appeals under Chapter 108D of the General Statutes, an LME/MCO is considered an agency as defined in G.S. 150B-2(1a). The LME/MCO shall not be considered an agency for any other purpose.
>
> N.C. Gen. Stat. § 150B-23 (a3)

18. The undersigned has addressed the issue of N.C. Gen. Stat. § 150B-23 (a3) in prior orders in this contested case, finding specifically that OAH has jurisdiction to hear this contested case and that § 150B-23 (a3) does not impinge OAH's jurisdiction in this case at all.

19. Chapter 108D of the General Statutes principally applies to Medicaid enrollees or recipients. It does not apply to this contested case other than the definitions. N.C. Gen. Stat. § 150B-23(a3) makes the LME/MCOs equivalent to DHHS; it makes the LME/MCOs "the" agency for disposition of recipient cases.

20. It is well settled law that DHHS is the single state agency responsible for Medicaid. For whatever reasons the General Assembly gave LME/MCOs that status for recipient cases. LME/MCOs have consistently been held to be the agent for DHHS which contracts to provide particular services. The last line of G.S. 150B-23(a3) does not change that relationship. It merely states that the LME/MCOs are not the agency for any purpose other than recipient cases. The distinction is between being the agency itself as opposed to being an agent of the agency.

21. 42 CFR § 438.214 entitled "*Provider Selection"* requires the State to ensure, through a contract, that each MCO/PIHP "implements written policies and procedures for selection and retention of providers.") (Pet. Ex. 22) (Emphasis added). Alliance admits that it is subject to this regulation.

22. A plain reading of the law makes clear that MCOs that operate a PIHP, such as Alliance, are required to have written policies and procedures for retention of providers. The fact that the law requires Alliance to have policies and procedures relating to provider retention means that Alliance must follow those policies and procedures. Requiring policies and procedures would be pointless if they are not followed.

23. 42 C.F.R. § 438.214(e) requires MCO/PIHPs to "comply with any additional requirements established by the State." The State through its contract with Alliance has established certain criteria for provider selection and retention that Alliance must follow.

24. Alliance has created a Provider Operations Manual and an RFP pursuant to the federal regulation and the State contracts. To the extent that Alliance's policy states that it can decide not to retain a provider for any reason at its sole discretion, such a policy does not conform with Federal law and the State requirements.

25. Alliance cannot circumvent federal law and State requirements that it have policies and procedures for deciding if a provider will be retained by creating a policy that allows it to make the determination for any reason in its sole discretion. Such a provision is tantamount to having no policies and procedures at all.

26. The federal law and the State contract requirements demonstrate that Alliance is incorrect that this case is a simple contract dispute and that courts have no right to force a party to enter into a contract against its will. Unlike contracts between two private parties, the contract at issue in this case is a contract that allows a Medicaid provider to participate in the Medicaid program, pursuant to a Medicaid waiver. Alliance's authority over Carolina Community and every other provider in its network only exists because of the Medicaid waiver. Without such a waiver, and DHHS's delegation of authority, Alliance would have no right to manage public funds. With this responsibility comes legal obligations. One of those obligations is to create and subsequently abide by provider selection and retention criteria. Alliance has created retention criteria and RFP policies. It must abide by them. As long as Alliance manages Medicaid dollars pursuant to a Medicaid waiver, it must abide by the laws and requirements that are attached to these funds.

27. Alliance also contends that this Court has no authority to determine Alliance violated 42 C.F.R. § 438.214 because the statute does not create a specific private right of action for providers.

28. A "private cause of action" is defined as a private person's right to invoke a federal enforcement statute against another private person in a civil suit. *See* James T. O'Reilly, Deregulation and Private Causes of Action: Second Bites at the Apple, 28 Wm. & Mary L. Rev. 235 (1986-1987); *see also Cort v. Ash*, 422 U.S. 66, 74 (1975). The case before this Court is not a private civil suit. Instead, Petitioner seeks an administrative review, pursuant to N.C. Gen. Stat. Chapter 108C. Thus, the analysis offered by Alliance has no applicability because it relates to private civil actions and not contested cases.

29. Alliance's contention also lacks merit because it ignores the standards by which an ALJ is expressly authorized to judge a contested case. N.C. Gen. Stat. § 150B-23(a)(5) states that an ALJ can consider that the Respondent "failed to act as required by law or rule." Indeed, OAH routinely finds that a Respondent's violation of state and federal law is the basis for reversing the administrative decision. *See Heartfelt Alternatives Inc., v. Alliance Behavioral Health*, 13 DHR 19958 (Dec. 11, 2014) (finding that Alliance acted contrary to 42 C.F.R. § 438.12 by not using Attachment O Provider Re-Enrollment Criteria when terminating provider from network); *see also Association For Home and Hospice Care of North Carolina, Inc., v. Division of Medical Assistance* 01 DHR 2346 (May 6, 2001) (finding that DMA's decision violated 42 C.F.R. §440.240 and 42 USC § 1396(a)(10)(B)).

30. Alliance's contention that its decision to not renew Carolina Community's contract based upon the RFP, and its own conclusion that it could refuse to renew for no reason at all, and that such was not an "adverse determination" is erroneous. The undersigned has previously addressed the fact that such is indeed an adverse determination.

31. Based on the Findings of Fact and Conclusions of Law above, Alliance failed to follow federal law and State requirements in its RFP process. Alliance also failed to properly follow its own policies and procedures, including its Provider Retention Policy and its RFP Procedure. Alliance has exceeded its authority, acted erroneously and failed to act as required by law or rule. N.C. Gen. Stat. § 150B-23(a).

32. Regarding Carolina Community's interview scores, the evidence demonstrates that these scores were erroneous, not supported by the RFP requirements, and not based on any statutory, regulatory or clinical coverage policy requirements. Based on the above findings of fact, Carolina Community should have received a passing interview score. Alliance has exceeded its authority, acted erroneously, and failed to act as required by law or rule. N.C. Gen. Stat. § 150B-23(a).

33. Under relevant North Carolina case law, decisions are arbitrary or capricious if they are "patently in bad faith, or whimsical in the sense that they indicate a lack of fair and careful consideration or fail to indicate any course of reasoning and the exercise of judgment." *Lewis v. N.C. Dept. of Human Res.*, 92 N.C. App. 737, 740, 375 S.E.2d 712, 714 (1989) (emphasis added).

34. The evidence in this case demonstrates that the RFP process and Alliance's interview scores were arbitrary and capricious because both clearly lacked fair and careful consideration. The Findings of Fact document several examples where the scores for a particular interview category were given in a haphazard and illogical manner. Alliance's blind reliance on its "closed network" in order to do its own biding lacked any fair and careful consideration. Alliance's actions are, therefore, arbitrary and capricious and violate N.C. Gen. Stat. § 150B-23(a)(4).

35. Based on the Findings of Fact, there is no basis for Alliance to terminate Carolina Community's participation in these Medicaid program and ability to operate as an agency-based CABHA provider in the Alliance network. Carolina Community should have received a passing interview score. The Alliance RFP process was not conducted in a manner that complied with federal law, the State Contract requirements, or Alliance's own policies and procedures.

36. Carolina Community has met every standard to continue to be a provider of IIH, CST, and SAIOP services in the Alliance Network. But for the erroneous and legally improper RFP decision, Carolina Community could still participate in these Medicaid program and could still qualify as a CABHA.

37. Alliance's decision to terminate Carolina Community's ability to participate in these Medicaid programs as an agency-based CABHA provider was in excess of Alliance's authority, erroneous, in violation of the law and Alliance's own policies and procedures, and arbitrary and capricious. N.C. Gen. Stat. § 150B-23(a).

DECISION

NOW, THEREFORE, based on the foregoing Findings of Fact and Conclusions of Law, the Undersigned determines that Respondent substantially prejudiced Petitioner's rights, acted outside its authority, acted erroneously, acted arbitrarily and capriciously, used improper procedure, and failed to act as required by law or rule in its decision to terminate Carolina Community as a provider of CST, IIH, and SAIOP services in the Alliance service area. The

Undersigned also finds that the RFP process itself violated procedure and law and was arbitrary and capricious in its design and implementation. Respondent's decision is hereby **REVERSED**.

Alliance is accordingly ordered to disregard its RFP findings and treat Carolina Community as it would any other provider that was offered a contract extension based on the RFP process. Based on the evidence in the record, this means that Carolina Community should be allowed to continue to provide these services until such time as Alliance determines that Carolina Community should not be retained in its network based on the requirements of federal law, the State contract, and its own policies as interpreted herein.

This Court further finds that reasonable attorney's fees should be awarded to Petitioner pursuant to N.C. Gen. Stat. § 150B-33(b)(11). As set forth above, Respondent's decision was arbitrary and capricious and substantially prejudiced Petitioner.

NOTICE

Under the provisions of North Carolina General Statute § 150B-45, any party wishing to appeal the final decision of the Administrative Law Judge must file a Petition for Judicial Review in the Superior Court where the person aggrieved by the administrative decision resides. The appealing party must file the petition within 30 days after being served with a written copy of the Administrative Law Judge's Final Decision. In conformity with the Office of Administrative Hearings' Rule, 26 N.C. Admin. Code 03.012, and the Rules of Civil Procedure, N.C. General Statute lA-1, Article 2, this Final Decision was served on the parties the date it was placed in the mail as indicated by the date on the Certificate of Service attached to this Final Decision. N.C. Gen. Stat. § 150B-46 describes the contents of the Petition and requires service of the Petition on all parties. Under N.C. Gen. Stat. § 150B-47, the Office of Administrative Hearings is required to file the official record in the contested case with the Clerk of Superior Court within 30 days of receipt of the Petition for Judicial Review. Consequently, a copy of the Petition for Judicial Review must be sent to the Office of Administrative Hearings at the time the appeal is initiated in order to ensure the timely filing of the record.

This the 2nd day of April, 2015.

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Donald W. Overby
Administrative Law Judge