STATE OF NORTH CAROLINA	**THE OFFICE OF ADMINISTRATIVE HEARINGS**
COUNTY OF WAKE	**14 DHR 1503**
SUNRISE CLINICAL ASSOCIATES, PLLC,)) **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 December 11, 2014, in Raleigh, North Carolina.

APPEARANCES

For Petitioner Sunrise Clinical Associates, PLLC ("Petitioner" or "Sunrise"):

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 ("Alliance"):

Joseph T. Carruthers
Wall Esleeck Babcock
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. Ch. 108C, Art. 3 of N.C. Gen. Stat. Ch. 150B, and 42 C.F.R. § 438.214.

BURDEN OF PROOF

Under N.C. Gen. Stat. § 108C-12(d), Respondent Alliance has the burden of proof in this contested case.

ISSUES

Petitioner Sunrise contends the issue to be resolved in this case is whether Respondent Alliance Behavior Healthcare, 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 Sunrise's ability to participate in the Community Support Team and Intensive In-Home programs.

Respondent Alliance contends the issues 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 Sunrise; 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

Joint Exhibits 1 through 23 were allowed into evidence. These exhibits are:

1. Contract between Alliance and DHHS (Contract #207-013)
2. Contract between Alliance and DHHS Division of Medical Assistance (Contract #28172)
3. Alliance's Provider Manual
4. Alliance's Operational Procedure #6023 - Request for Information/Request for proposal
5. Alliance's Operational Procedure # 6012 -- Provider Network Capacity and Network Development procedure
6. Alliance's RFP for IIH
7. Alliance's RFP for CST
8. Alliance's RFP for SAIOP
9. Alliance's RFP Selection Summary
10. Alliance's RFP PowerPoint
11. 2014 Contract between Alliance and 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)
12. 2014 Contract between Alliance and Carolina Outreach for RFP Services through December 31, 2014 (example of a contract given to providers who scored 65 and above on interview)

Joint Exhibits For Judicial Notice

1. 10A NCAC 22F .0101
2. 10A NCAC 22F .0605
3. Attachment 1.1B to the 1915(b) Waiver
4. 42 C.F.R. § 438.12
5. 42 C.F.R. § 438.214
6. OAH Order in *Family First v. Alliance*
7. OAH Order in *Essential Services v. Alliance*
8. OAH Order in *Miller v. Alliance*
9. OAH Order in *Yelverton's v. PBH*
10. Superior Court Order in *Cardinal v. Derwin*
11. Superior Court Order in *Yelverton's v. PBH*

Petitioner's Exhibits 1, 7, 8, 10, 14, 15, 20, 22, 23 were allowed into evidence. These exhibits are:

1. Alliance's Provider RFP Review Summary
7. Alliance RFP 2013 Interview Questions and Responses for IIH and CST – Master Response Sheet
8. Alliance RFP 2013 Interview Questions for CST and IIH – Reviewer: Tammy Ramirez
10. Alliance RFP 2013 Interview Questions for CST and IIH – Reviewer: Melissa Simpson
14. Sunrise Clinical's Proposal to Alliance for CST services
15. Sunrise Clinical Proposal to Alliance for IIH services
22. Sunrise Clinical's CBT Fidelity Monitoring Tools of their consumers
23. Alliance 7/1/13 letter to Sunrise Clinical concerning Sunrise Clinical's successful completion of the Gold Star Implementation review and that Sunrise Clinical was on "Routine Status" with Alliance

Petitioner's Exhibit For Judicial Notice

20. NCDHHS Provider CABHA website article, "CABHAs: Critical Access Behavioral Health Agencies" – with Senate Bill 525, Session Law 2012-171

Respondent's Exhibits 5-7, 8, 9, 12, 15, 20 and 21 were allowed into evidence. These exhibits are:

5. 2013 Contract between Alliance and Petitioner
6. Three-month extension to 2013 contract between Alliance and Petitioner (through
7. Non-renewal letter, Alliance to Petitioner dated January 10, 2014
8. Sign-in sheets for interview
9. Master Panel Response Sheet for Interview
12. Interview notes by Melissa Simpson
15. Affidavit by Melissa Simpson

20. 2014 Contract with Petitioner for non-RFP services
21. April 1, 2014 Contract Amendment with Petitioner following Preliminary

Additional Exhibits – Pursuant to the stipulation of the parties, all exhibits allowed into evidence in the related case, *Carolina Community Support Services v. Alliance Behavioral Healthcare,* 14 DHR 01500 have been admitted and will be cited below as (Pet. Ex.) and (Res. Ex.). Those exhibits are as follows:

Carolina Community Petitioner Exhibits:

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 RFP Committee Training, November 15, 2013
13. Alliance RFP Selection Summary
16. Alliance Behavioral Healthcare Provider Operations Manual
19. Carolina Community Intensive In-Home RFP Response
20. Carolina Community SAIOP RFP Response
21. Carolina Community 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

Carolina Community Respondent Exhibits:

1. Alliance's RFP for IIH
2. Alliance's RFP for CST
3. Alliance's 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 Petitioner
10. Three-month extension to 2013 Contract between Alliance and Petitioner (through 3/31/14)
11. Non-renewal letter from Alliance to Petitioner dated January 10, 2014
12. Training PowerPoint for interview
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 Petitioner's Exhibits 22, 23, and 26. These exhibits are as follows:

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

Carolina Community Respondent Exhibits:

1. Alliance's RFP for IIH
2. Alliance's RFP for CST

3. Alliance's 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)
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WITNESSES

Petitioner presented the testimony of:

1. Anya Odim, Owner Sunrise Clinical Associates

Respondent presented the testimony of:

1. Melissa Simpson, Employee, Alliance Behavioral Healthcare

Additional witnesses - Pursuant to the stipulations of the parties, all witness testimony in the related case, *Carolina Community Support Group, Inc. v. Alliance Behavioral Healthcare,*14 DHR 01500 has been admitted and considered by the Court. *The citations from the Carolina Community testimony will be prefaced with C.C.* The witnesses who testified in Carolina Community are:

Petitioner:
1. Oswald Nwogbo, CEO of Carolina Community Support Group, Inc.
2. Lamar Marshall, employee of Carolina Community Support Group, Inc.

Respondent:
1. William Carlyle Johnson, 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 Sunrise Clinical Associates, PLLC ("Petitioner" or "Sunrise") 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. Sunrise 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 on December 11, 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. Petitioner Sunrise is a provider of mental health and behavioral health services with its principal place of business in Raleigh, North Carolina. Sunrise 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. Sunrise was founded in 2007 and is a provider of Medicaid Intensive In-Home ("IIH") services and Community Support Team ("CST") services in the Alliance service area. (Pet. Ex. 1, p. 3; Odim, Vol. 1, pp. 167, 223). These services are Medicaid programs. (Johnson, Vol. 1, pp. 194–95).

3. Sunrise 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"). (Simpson, Vol. 1, pp. 56–57; Odim, Vol. 1, p. 225). Sunrise must provide CST or IIH services to continue to qualify as a CABHA. (Simpson, Vol. 1, p. 136; Odim, Vol. 1, p. 225; 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 (*I.d.*).

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 in North Carolina. *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; C.C. 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 prepaid inpatient health plans ("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) Medicaid Program. Alliance manages Medicaid mental health, developmental disability, and substance abuse services provided in Cumberland, Durham, Johnston, and Wake Counties. (Jt. Ex. 3, 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. (*Id.*, 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 C.F.R. § 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." (Jt. Ex. 17) (Emphasis added).

9. 42 C.F.R. § 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 C.F.R. § 438.214 is applicable to Alliance because it operates as a PIHP pursuant to a Medicaid waiver. (Johnson, Vol. 1, pp. 178–79).

11. In conformity with 42 C.F.R. § 438.214, Alliance has executed two contracts with DHHS. These contracts require Alliance to create Provider Selection and Retention policies. (Jt. Exs. 1, 2). 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." (Jt. Ex. 2, 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." (Jt. Ex. 2, 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. (Jt. Ex. 3, 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." (Jt. Ex. 4, p. 1).

The Alliance RFP

15. On September 30, 2013, Alliance announced that all current network providers of 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. 16, 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. (Pet. Ex. 12, p. 7; Johnson, Vol. 1, p. 168; Johnson, Vol. 2, p. 292). 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. 172–73). 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* Jt. Ex. 6 *with* Jt. Ex. 7, and Jt. Ex. 8). 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. Sunrise was offered a three-month contract, and it accepted and signed a contract with an ending date of March 31, 2014. (Respondent's Exhibit 6). The three-month contracts offered by Alliance, including the one with Sunrise, 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. (Jt. Exs. 6–8, 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.

(Jt. Exs. 6–8, 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.

(Jt. Exs. 6–8, 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. (Jt. Exs. 6–8).

25. The RFP also requested that each provider include three references. The RFP indicates that references would be checked to "verify the accuracy of submitted materials and to ascertain the quality of past performance." (Jt. Ex. 6, p. 11; Jt. Ex. 7, 8, 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. 16, p. 1).

27. As part of this training, Alliance created a 14-page PowerPoint presentation. (Pet. Ex. 16; 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. (Simpson, Vol. 1, pp. 128, 151; CC. Estes, Vol. 1, p. 105; Johnson, T. Vol. 1, pp. 217–20; Pet. Ex. 16).

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. 16, p. 13). The scale contains general descriptive terms for the 1–5 scores. 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. (Simpson, Vol. 1, pp. 128, 151; Johnson, Vol. 1, pp. 226-227; C.C. Alston, Vol. 2, p. 501). During the interview stage, the reviewers did not have a copy of the RFP when it assigned scores and did not compare the Sunrise's responses to the requirements, preferences or information requested in the RFP. (Simpson, Vol. 1, pp. 72, 128).

30. The RFP contained no information or guidance to reviewers indicating how the Likert Scores of 1–5 should be assigned. (Jt. Ex. 6–8). The only substantive guidance contained in the RFP are the preferences and the six Scope of Work requirements. (Jt. 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*., pp. 326–27). 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. 16; Jt. Exs. 6–8).

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 process 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 processes, testified that the training never included what an answer should look like, or what the requirements were. (Estes, Vol. 1, pp. 105–06, 115).

33. Instead, RFP reviewers were instructed to use their own experience and judgment when assigning scores. (Johnson, Vol. 1, p. 239). Alliance admitted that this standard was subjective in nature. (Simpson, Vol. 1, p. 154; 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. 3, p. 4; 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 in response to a question, while another interview panel might believe that providing information regarding HIPAA compliance was unnecessary**.** (Rieber, Vol. 2, p. 423). Two Alliance employees testified that for CABHA medical directors the "preference is for psychiatrists." (Simpson, Vol. 1, pp. 19, 79; Johnson, Vol. 1, p. 252). No such preference is expressed by Alliance in its RFPs. (Jt. Exs. 6–8).

Sunrise's RFP Review

36. The Alliance RFP Review Process consisted of three steps once a provider submitted its written proposal. (Jt. Ex. 6, pp. 12–13; Johnson, Vol. 1, p. 32–34, 40). First, Alliance reviewed the written proposal to determine if the provider met minimum criteria. (Jt. Ex. 6, p. 12;

Johnson, Vol. 1, p. 32). Both of Sunrises 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. 218–19). The RFP sections scored by Alliance in the Desk Review included: the Executive Summary (5%); Organizational Background (10%); Clinical Programming and Response to Scope of Work (50%); Legal and Compliance Information (10%); Financial Information (20%); and Technological Capability (5%). (Pet. Ex. 16, p. 10; Jt. Exs. 6–8, 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. 307–08). For the Clinical Programming 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 Programming Score and Alliance used the highest average score as the provider's Clinical Programming 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, Sunrise received a score of 69.1% for the IIH review and 75.1% CST review. (Pet. Ex. 1, p. 3). Thus, Sunrise qualified for an interview for these services.

40. The evidence shows that the Desk Review scores for the Clinical Review portion of the Desk Review varied significantly depending on who conducted the review. In Sunrise's IIH Desk Review one clinical reviewer scored Questions 2 and 3 as a 4. (Pet. Ex. 4, pp. 2, 3). This means that the reviewer felt that Sunrise's response was good, strong, well-planed and clear. (*Id*.). The other clinical review scored the same questions as a 2 and a 2.5. (Pet. Ex. 5, pp. 2, 3). This means that the reviewer felt the exact same response was minimal, weak, and confusing. (*Id*.).

41. The evidence demonstrates that this variation in the scoring was systemic. In 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). The other 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). For almost 50% of the clinical questions in Carolina Community's Desk Review, the reviewers had completely different understandings of what was required in the RFP. When Ms. Estes was asked about the difference in scores, Ms. Estes testified that this was the result of the fact that she and Ms. Rieber had "different backgrounds and experiences." (Estes, Vol. 1, p. 151).

42. Ms. Estes' testimony in *Carolina Community* reveals a very troubling aspect of this 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. (Estes, Vol. 1, p. 151). As evidenced by the wide variation in the scores assigned in the Desk Review, it is clear to the Undersigned that these scores have little to no value because they were not based on whether the *provider's answer* complied with established criteria but instead were determined by how the *reviewer's skills and experience* meshed with the provider's response.

43. Dr. Johnson was not clear about 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

44. The final step of the RFP process was an interview (the "Interview"). At the interview stage a panel of reviewers asked providers a series of nine scripted questions corresponding to nine scoring categories. (Pet. Ex. 7). The individuals that made up the provider interview panel varied from provider to provider. (Johnson, Vol. 1, p. 41; Vol. 2, pp. 314–15).

45. 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.

46. Despite the fact that Alliance was aware that its reviewers had applied different standards during the Desk Review process Alliance undertook no efforts to discuss these discrepancies and did not provide the reviewers with any additional guidance, training or feedback before these reviewers conducted interviews. (Johnson, Vol. 1, pp. 224–25; Estes, Vol. 1, pp. 101–02).

47. 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.

48. As with the Desk Review Scores, at the interview a provider's scores were not based on objective and identifiable criteria but instead were 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.

49. As with the Desk Review, the interview panel used the Likert score of 1–5 for scoring these nine questions. (Pet. Ex. 16, p. 13; Simpson, Vol. 1, p. 29; 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 forth in Findings of Fact above. (Johnson, Vol. 1, pp. 40–42).

50. 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).

51. 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. 137–38; Johnson, Vol. 2, p. 314).

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

Sunrise's Interview Scores

53. Sunrise received a score of 52.2% for both its CST and IIH services. (Pet. Ex. 1, p. 3). Sunrise'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, pp. 3, 4; Pet. Ex. 7).

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

Question 1 – Organizational Strengths

56. The first question asked by the interview panel was: "[T]ell us briefly about the strengths of your organization and what sets your agency apart from others providing similar services." (Pet. Ex. 7, p. 1).

57. Sunrise outlined several of its strengths, including that it had two medical directors, a clinical director who provided clinical oversight, was in a good financial position, and that the QI/QM director had extensive experience with compliance issues because she had previously worked for many years in quality management and provider compliance at the Durham Center (the predecessor to Alliance). (Pet. Ex. 7, p. 1). Sunrise also mentioned its diversity, the fact that they had translators on staff, and that its medical director and clinical staff all met to determine the needs for the consumers, which is not a requirement. (*Id*.).

58. Sunrise received a score of 2.5 for this question. (Pet. Ex. 1, p. 3). Alliance's justification for this score was that the organization did not appear to have a well-developed organizational infrastructure for implementation of evidence-based practices, staff supervision, staff recruitment and retention, and quality management. (Pet. Ex. 1, p. 3).

59. Ms. Simpson testified that the interview panel's low score did not relate to the question asked by Alliance because Sunrise was not asked to address evidence-based practice, staff supervision, staff recruitment, or quality management in this question. (Simpson, Vol. 1, p. 48). The interview panel was not given any guidance that the provider should address these four items listed in the justifications for low score for this question. (*Id*., p. 49). The interview panel was not told that if a provider did not address these four topics in the first question, they should be scored below average. (*Id.* p. 49).

60. The basis for the interview panel's score for Question 1 related to Sunrise's responses to other questions, mainly questions 5 and 9. (*Id*., pp. 48–49). These questions however each received their own score.

61. In comparing the response for Question 1 by Sunrise and Carolina Community it is apparent that the responses were very similar. **(***Compare* Pet. Ex. 7, p. 1, *with* Pet. Ex. 2, p. 1). Indeed, Alliance admits that Carolina Community did not address evidence-based practices, staff retention, staff recruitment, or quality management in its response to Question 1. (Simpson, Vol. 1, p. 51). Carolina Community received a score of 3.5 for the *Organizational Strengths* category. Alliance's witness could not explain this discrepancy. (*Id.*).

62. Based on the Findings of Fact above, the Sunrise score of 2.5 was not based on the response to the question asked or on criteria that related to the question. Instead, Alliance based its score on responses to other questions, which received their own score. The disparity between the Sunrise and Carolina Community scores, in light of the answers provided, demonstrate the arbitrary and capricious nature of this review.

Question 2 – Medication Management and Psychiatric Capacity

63. The second set of questions asked by the interview panel was: "[D]oes your agency have access to medication management and psychiatric services within the local community? Does your agency have access to telepsychiatry services?" (Pet. Ex. 7, p. 1). Sunrise received a score of 3 in the *Medication Management and Psychiatric Capacity* category. *(Id.).*

64. Sunrise's response to this statement indicated that it has two medical directors, one that specifically focuses on adults and geriatrics and one that focuses on children. (Odim, Vol. 1, p. 176–177; Simpson, Vol. 1, p. 64; Res. Ex. 13, p. 1). Sunrise also informed the interview panel of the number of hours of medication management provided. (Res. Ex. 13, p. 1). In response to the telepsychiatry question, Sunrise answered that it uses such technology for internal communication but not for direct patient care. (Pet. Ex. 7, p. 1).

65. Alliance provided no basis for why Sunrise only received a score of 3 in this category. (Pet. Ex. 1, p. 3). A score of 3 indicates that the provider's response was sufficient, but that some questions or concerns remained. (Pet. Ex. 16, p. 13). When asked about how the interview panel would differentiate between a score of 3 and 4, Ms. Simpson had no answer. (Simpson, Vol. 1, p. 66). Ms. Simpson testified that there was no specific guidance given to the reviewers because of the number of variables involved. (Simpson, Vol. 1, p. 69). However, in the *Medication Management and Psychiatric Capacity* criteria, the question is very straightforward. Does the provider provide medication management and have psychiatric capacity? (Pet. Ex. 7, p. 1).

66. Based on the above, Alliance has not shown why Sunrise received an average score of 3 for this question. Sunrise fully answered the question asked and met all of the requirements and preferences in the RFP for this question. Accordingly, its score should have been higher than a 3 in this category.

Question 3 –CABHA Medical Director and Clinical Oversight

67. The third set of questions asked during the interview was: "[D]escribe the role of your medical director; how much time is allotted for administrative oversight vs. direct patient care. Is direct supervision provided to medical staff or other clinical staff? (Pet. Ex. 7, p. 1). Sunrise received a 3 for this question. (*Id*.). When asked about how the interview panel would differentiate between a score of 3 and 4, Ms. Simpson had no answer. (Simpson, Vol. 1, p. 66).

68. In its response, Sunrise indicated that its two Medical Directors spend eight hours and six hours per week on administrative time and that this represented about 40% of these medical directors' total time. (Res. Ex. 11). The Alliance reviewer testified that one of the reasons that this response was scored as a 3 was because the CABHA rules required the Medical Director to spend ten hours on administrative duties. (Simpson, Vol. 1, p. 73). She later admitted that the CABHA statute does not require a specific number of administrative hours for a CABHA medical director. (*Id.*). Additionally, Alliance's RFP only states a preference for the medical director providing ten hours of services per week and does not express any preference regarding how that time should be broken down between clinical and administrative time. (Jt. Ex. 6, p. 5). In Sunrise's case, the total medical director's time far exceeded ten hours.

69. Based on the above Findings of Fact, the score of 3 for CABHA Medical Director and Clinical Oversight was based on standards created by the interview panel, which are not found in the CABHA statute or in the RFP. The score of 3 is therefore erroneous.

Question 4 – Staffing for Services

70. The fourth set of questions asked was: "[C]an you describe how you staff this service? Are they contract or employees? How do you cover staff vacancies? (Pet. Ex. 7, p. 2). Alliance received a score of 2 for this question. (*Id.*). Alliance's score justification indicates that a 2 was assigned because Sunrise did not have an adequate plan for coverage of vacancies, insufficient plan for staff supervision, limited information about staff recruitment and retention and that the program supervisor was provisionally licensed. (Pet. Ex. 1, p. 3).

71. Sunrise fully and sufficiently informed Alliance of its plans in case a vacancy occurred. First, the program supervisor, who is provisionally licensed, can serve as the direct care provider if there is a vacancy. (Odim, Vol. 1, pp. 191–92). Second, Sunrise has contracted with a staffing company that prescreens individuals who are qualified and ready to be immediately hired should there be a vacancy. (*Id.*, pp. 193–94).

72. Similarly, Alliance's justification that Sunrise provided limited information about approaches to staff recruitment and retention is not supported by the evidence. Sunrise made clear that it had a staffing company, which had prescreened, qualified individuals that Sunrise could hire if additional staff were needed. (Odim, Vol. 1, pp. 193–194). Ms. Simpson stated that her concern was that that Sunrise could not retain its staff if they were contract employees. (Simpson, Vol. 1, pp. 94–95). The RFP sets forth no requirement regarding contract employees, and the interview panel had no basis to impart its personal concern over such an issue.

73. In regard to justification regarding insufficient staff supervision, the question did not ask Sunrise to provide any information about staff supervision. (Pet. Ex. 7, p. 2). Staff supervision was reviewed during the Gold Star Monitoring. (Pet. Ex. 23). Sunrise received a score of 100% on the staff section of the review. (*Id.*). If Alliance would have used the provider's compliance history as was required by Alliance's RFP policy, the interview panel would have known that Alliance received a perfect score when Alliance reviewed Sunrise's staff supervision documentation.

74. Finally, Alliance found in its justification for the low score assigned in this category that Sunrise's Program Supervisor is provisionally licensed. (Pet. Ex. 1, p. 4). There is no requirement that a provider have a Program Supervisor and thus there are no preferences in the RFP that the program supervisor be fully licensed and not just provisionally licensed. (Odim, Vol. 1, p. 190, Jt. Exs. 6–8).

75. Sunrise created the position of program supervisor on its own to provide additional oversight and assistance to the required staff and to fill in when a staff member is sick or leaves the positon. (Odim, Vol. 1, pp. 190–91). Sunrise was essentially punished by the interview panel for having extra oversight of its program. Mr. Odim testified that, after reviewing the findings, Sunrise might have been better off not to have hired this additional non-required position (Odim, Vol. 1, p. 198).

76. The fact that a staff who fills a position, which is not required by the clinical coverage policy and is not even contemplated in the RFP, is only provisionally licensed cannot serve as the basis for a low score.

77. Based on the Findings of Facts above, a score of 2 was not justified in this category.

Question 5 – Evidence-Based Practices and Measures Fidelity

78. The fifth question related to the use of evidence-based practices and measuring fidelity. (Pet. Ex. 7, p. 2). Sunrise received a score of 2 in this category. (Pet. Ex. 1, p. 4).

79. Alliance justified its score by stating that Sunrise confused outcomes with fidelity, failed to provide a specific vision or a model for the enhanced services they will deliver, and failed to articulate well how evidence based practices would be implemented or how practices would apply to the population served. Alliance also states that Sunrise did not have a well-developed plan for measurement of fidelity and ensuring implementation of evidence based practices. (Pet. Ex. 1, p. 4). Fidelity in this context means the ways by which a provider measures whether its staff is following evidence based practices when it provides services. (Simpson, Vol. 1, pp. 102–103).

80. As to the justifications that Sunrise confuses outcomes with fidelity, Alliance agreed that outcomes could be used to measure fidelity. (Simpson, Vol. 1, p. 107). Further, the interview notes demonstrate that Sunrise explained to the panel that it measures fidelity in more ways than just measuring outcomes, including through supervision. (Pet. Ex. 7, p. 2; Odim, Vol. 1, p. 201).

81. In its written RFP response, Sunrise provided a fidelity tool that it created and uses to assist in measuring fidelity. (Pet. Ex. 22; Odim, Vol. 1, p. 199). Sunrise's fidelity tool is a checklist that shows the ways Sunrise measures fidelity. (*Id*.). The fidelity tool demonstrates that Sunrise measures fidelity in a myriad of ways including by direct supervision of its staff and by videotaping staff interaction with consumers. (Pet. Ex. 22, Odim, Vol. 1, pp. 199-201). This fidelity tool was included in Sunrise's RFP response. (Pet. Ex. 22; Odim, Vol. 1, p. 199). Sunrise mentioned its fidelity checklist during the interview. (Simpson, Vol. 1, p. 112). Ms. Simpson admitted that she failed to review the RFP to see how Sunrise monitors fidelity through its fidelity tool and if she would have reviewed the RFP, it would have contained information that may have been helpful to her. (Simpson, Vol. 1, p. 115).

82. Based on the above Findings of Fact, the score of 2 for this category was erroneous and not supported by the facts in the records.

Questions 6 and 7 – Alternative Levels of Care and Service Capacity

83. For Question 6, *Assessment for Alternate Levels of Care*, Sunrise received a 3. (Pet. Ex. 1, p. 5). Alliance could provide no basis for why Sunrise's response only deserved a 3 and not a 4. (Simpson, Vol. 1, p. 116).

84. For Question 7, *Service Capacity and Plans for Acceptance of Transitioned Consumers*, Sunrise also received a 3. (Pet. Ex. 1, p. 5). Sunrise provided a great deal of information to the interview panel about its ability to take on a specific number of clients if necessary. (Pet. Ex. 7, p. 2; Odim, Vol. 1, pp. 207–08). Again, Ms. Simpson could not recall why Sunrise should have been given a score of 3, instead of 4 in this category. (Simpson, Vol. 1, p. 118). Ms. Simpson conceded that Sunrise's response to the service capacity question was specific. However, when asked how the interview panel determined that the response was only sufficient with some questions remaining, she could not recall. (Simpson, Vol. 1, pp. 120–21).

85. Based on the above Findings of Fact, the scores of 3 for Question 6 and 7 were erroneous and not supported by the facts in the records.

Question 8 –Community Partnerships and Diversity of Population Served

86. Question 8 related to the providers community partnerships and diversity of the population served. Sunrise received a 3. (Pet. Ex. 7, p. 3). Again, Ms. Simpson could not recall why the committee gave Sunrise a 3 and not a 4 in this category. (Simpson, Vol. 1, p. 123–24).

In response to the *Community Partnerships and Diversity of Population* category, Sunrise provided an extensive list of community agencies for which it has partnerships. (Odim, Vol. 1, pp. 209–210; Simpson, Vol. 1, pp. 121–122 Pet. Ex. 7, p. 3). Sunrise also provided a large number of diverse communities it serves, including the LGBT community, the Hispanic community, and HIV males and noted its use of translators. (*Id*.).

87. In this category Carolina Community received a score of 4. (Pet. Ex. 2, p. 2). It is apparent by comparing Carolina Community's response and Sunrise's response that they are very similar. (Odim, Vol. 1, p. 211; *compare* Pet. Ex. 2, p. 2, *with* Pet. Ex. 7, p. 3). The difference in the score appears to be based on the subjective nature and judgment of interview panels. (Odim, Vol. 1, pp. 211–12).

88. Based on the above Findings of Fact, the score of 3 was not supported by facts and was erroneous.

Question 9 – Quality Management

89. In the final category, *Quality Management*, Sunrise received a score of 2. (Pet. Ex. 1, p. 5). Alliance cited as its justification for this score that the provider did not demonstrate expected quality management protocols and practices, including quality improvement measures and incorporation of consumer-driven principles. (*Id*.).

90. The question asked by Alliance for this category was: "[T]ell us about complaints, grievances, and incidents. What have you learned through the reviews and what are you doing differently?" (Pet. Ex. 9). Sunrise provided a lengthy explanation of its grievance process and what it had learned through that process. (Pet. Ex. 7, p. 3; Odim, Vol. 1, p. 214; Simpson, Vol. 1, p. 125). Ms. Simpson admitted that Sunrise's interview response focused on the question that was asked. (Simpson, Vol. 1, p. 124).

91. Based on the above Findings of Fact, the scores given to Sunrise 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 Sunrise 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 by the RFP, the interview panel simply substituted its own subjective judgment by assigning scores to Sunrise that were not related to the RFP requirements and preferences.

Federal Requirements for Retention of Providers

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

93. Sunrise's contract was in in effect for a period between February 2013 and December 31, 2013. The contract of Sunrise, and every other provider that met the minimum criteria, was extended through March 2014. (Res. Ex. 6; Res. Exs. 29A, 29B, 29C).

94. Alliance contends that Alliance, at is 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.

95. 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 C.F.R. § 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." (Jt. Ex. 17) (emphasis added). 42 C.F.R. § 438.214(e) requires MCO/PIHPs to "comply with any additional requirements established by the State."

96. 42 C.F.R. § 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/PIHP will exclude providers that are excluded by the federal health care program. *See* 42 C.F.R. § 438.214.

97. Alliance's witness, Carlyle Johnson, agreed that 42 C.F.R. § 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 C.F.R. § 438.214, which requires Alliance to have selection and retention policies.

DHHS Contract Requirements Relating to Provider Retention

98. Pursuant to 42 C.F.R. § 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." (Jt. Ex. 1, p. 23).

99. 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. (Jt. Ex. 2, pp. 32–33).

100. 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.

(Jt. Ex. 2, p. 92, Contract Attachment O).

101. 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." (Jt. Ex 2, 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.

102. As a CABHA in the Alliance network, Sunrise must provide IIH or CST services in order to continue to be a CABHA. (Johnson, Vol. 1, pp. 186–87; Simpson, Vol. 1, p. 136). Thus, Alliance's RFP decision determined whether Sunrise would be maintained or terminated as an agency-based Medicaid provider.

103. The DMA Contract also required Alliance's decision to be based on "identified indicators and benchmarks." (Jt. Ex. 2, 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.

104. 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." (Jt. 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

105. 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. (Jt. Ex. 3, pp. 35–38; Johnson, Vol. 1, p. 180).

106. 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 Sunrise is already a provider in the Alliance network. (Jt. Ex. 3, p. 35).

107. 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." (Jt. Ex. 3, p. 36).

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

109. The Retention Criteria states that the Alliance Provider Network Management Committee ("PNMC") is responsible for making decisions about contract renewal and provider network reductions. (Jt. Ex. 3, p. 36). The evidence demonstrates that, in this case, the PNMC did not make the determination whether Sunrise would be retained. (Johnson, Vol. 1, pp. 207-208).

110. 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 the criteria in this RFP.

111. The Retention Criteria also states that Alliance "has the right to renew a contract with a Network Provider for any reason . . . in the sole discretion of Alliance." (Jt. Ex. 3. p. 37). Alliance cites 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).

112. 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.

113. 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. 371–72).

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.

114. 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 into the network. Sunrise is already a provider in the network. Instead, this case is about whether Sunrise would be retained in the network. There is no evidence that Alliance made a determination that it had "sufficient providers."

115. 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. (C.C. Pet. Exs. 3, 4).

116. 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).

117. 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, Sunrise 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* N.C. Gen. Stat. Ch. 108D.

118. 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.

119. 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.*, pp. 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 Sunrise's termination. (*Id.*). One

120. One of the conditions in Alliance's provider retention policy for non-renewal is that Alliance issues an RFP or RFI. (*Id.*, p. 38). However, this 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. Further, 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. (Jt. Ex. 2, p. 94, Attachment O).

Alliance's RFP Procedures

121. 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." (Jt. Ex. 4, 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*.).

122. The RFP Procedure requires Alliance to create and organize a RFP Selection Committee consisting of at least five members and reflecting relevant community stakeholder representation, including one or more Consumer and Family Advisory Committee ("CFAC") members and/or consumers representing the disability affected by the RFP. (Jt. Ex. 4, p. 2, Sec. 2.C.d). Alliance failed to follow this requirement. (Johnson, Vol. 2, p. 375). Ms. Simpson testified that she did not realize that she was serving on the selection committee and did not know who the selection committee was when her interview panel made the decision not to retain Sunrise. (Simpson, Vol. 1, pp. 154-155).

123. 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).

124. The RFP Procedure also requires Alliance to develop a RFP Scoring Sheet based upon Bidder Criteria and Response Requirements outlined in the RFP template. (Jt. Ex. 4, 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).

125. 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. (Jt. Ex. 4. 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. In addition, the DMA Contract required Alliance to base its decision on the demonstrated performance of the agency. (Jt. Ex. 2, p. 94, Attachment O).

126. Specifically, as it relates to Sunrise, a review of its past compliance history would have been important. Alliance had conducted a thorough state-mandated review of Sunrise called "Gold Star Monitoring" only a few months prior to the interview. (Pet. Ex. 23; Odim, Vol. 1, pp. 172–173)

127. Sunrise received a total score of 99% in this monitoring, with no score in any category below 97%. (Pet. Ex. 23). This score would constitute a very good score in this review. (Rieber, Vol. 2, p. 405). 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, who 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 Sunrise's Gold Star Monitoring Score. (Pet. Ex. 27; Jt. Ex. 4, p. 2, Sec. D.3).

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

129. According to Ms. Simpson, Alliance only wanted the highest quality providers in its network. (Simpson, Vol. 1, p. 144). Yet, the interview panel completely ignored Sunrise's compliance history that documented that it received nearly the highest possible score when Alliance conducted a comprehensive review of its services. According to Ms. Simpson in determining the highest quality provider, it would be necessary to have a combination of both an interview and reviewing the service history of the provider agency. (Simpson, Vol. 1, p. 146). There was no review of Sunrise's service history as part of the process which terminated it's services herein.

130. 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. (C.C. Estes, Vol. 1, pp. 137–38; Johnson, Vol. 2, pp. 313–14).

131. 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 Sunrise's 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

132. 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.

133. At the expiration of those contracts, the providers that were selected through the RFP process were all provided contract extensions 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).

134. Sunrise has continued to provide services pursuant to a stay issued by this Court. (Simpson, Vol. 1, p. 138). Alliance presented no evidence that Sunrise had any compliance issues during this time period. Under the criteria set forth by Alliance, if Sunrise would have been awarded a contract extension under the RFP, it would still be allowed to provide services in 2015.

135. According to Ms. Simpson that Alliance had sufficient capacity in the network to serve consumers who need IIH and CST services without having Sunrise as a provider. (Simpson, Vol. 1, p. 135). There is no evidence to support this statement. Ms. Simpson could not provide even a rough approximation of the number of IIH and CST providers in Alliance's service area. (*Id*., p. 136). Ms. Simpson had no knowledge of the expected Medicaid growth rate in either Durham or Wake County, and had not seen any projection of the number of consumers in Durham or Wake County that will need services in 2015. (*Id*.). Ms. Simpson did not know how many CST and IIH teams were available in Durham or Wake County that had immediate availability to take on Sunrise's consumers if it were not allowed to continue to participate. (*Id*., pp. 137–39). Ms. Simpson admitted that when she testified that Alliance has a sufficient number of providers to serve the recipients in the Alliance service area, she had reviewed no data. (*Id.*, p. 143). The only evidence is that there was no data.

136. The fact that Ms. Simpson was willing to testify that Alliance had a sufficient number of providers without first reviewing some data is very troubling and calls into question her credibility as a witness.

137. According to Ms. Simpson, Alliance just did not want Sunrise as a provider in its network. (Simpson, Vol. 1, p. 135). When asked about the basis of this opinion, Ms. Simpson could cite nothing other than the RFP. (*Id*., pp. 143–44). Alliance's position obviously reflects its contention that it could do as it pleased because it has a closed network.

138. 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 Motions to Dismiss made by Alliance all parties are properly before the Office of Administrative Hearings, and this tribunal 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 Sunrise has no right to be a Medicaid provider, and, therefore, this Court should not find that Sunrise's rights have been substantially violated by its decision. Alliance instead argues that Sunrise's rights are solely contractual in nature and once the contract expired, Sunrise 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. Dep't 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. Interpreting North Carolina law, the United States Court of Appeals for the Fourth Circuit 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 enactment and codification 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 interest 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 provider a right to not be terminated in a manner that (1) violates applicable law or rule; (2) is in excess of the Department's authority or jurisdiction; (3) is erroneous; (4) is arbitrary and capricious; or (5) fails to use proper procedure. 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 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 this 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. Ch. 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 Sunrise 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 C.F.R. § 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." (Jt. Ex. 17) (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 contract 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 Sunrise and every other

provider in its network only exists because of the Medicaid waiver. Without such a waiver, 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. Under federal law, it must abide by them. As long as it 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. This argument lacks merit.

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. Ch. 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 adjudicate 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 Healthcare,* 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 Ass'n for Home and Hospice Care of N.C., Inc. v. Div. of Medical Assistance*, 01 DHR 2346 (May 6, 2001) (finding that DMA's decision violated 42 C.F.R. §440.240 and 42 USC § 1396a(a)(10)(B)).

30. Alliance's contention that its decision to not renew Sunrise'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 follow its own policies and procedures, including its Provider Retention Policy and its RFP Procedure. Alliance has exceeded its authority, acted erroneously, failed to act as required by law or rule, and failed to use proper procedure. N.C. Gen. Stat. § 150B-23(a).

32. Regarding Sunrise'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, Sunrise should have received a passing interview score. Alliance has exceeded its authority, acted erroneously, failed to act as required by law or rule, and failed to use proper procedure. 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. Dep't of Human Res.,* 92 N.C. App. 737, 740, 375 S.E.2d 712, 714 (1989).

34. The evidence in this case demonstrates that Alliance's interview scores were arbitrary and capricious because they indicate a clear lack of fair and careful consideration. The Findings of Fact document many 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 Sunrise's participation in these Medicaid program and ability to operate as an agency-based CABHA provider in the Alliance network. Sunrise 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. Sunrise has met every standard to continue to be a provider of IIH and CST services in the Alliance Network. But for the erroneous and legally improper RFP decision, Sunrise could still participate in these Medicaid program and would still qualify as a CABHA.

37. Alliance's decision to terminate Sunrise's ability to participate in these Medicaid programs as an agency-based CABHA provider was in excess of Alliance's authority, erroneous and in violation of the law and Alliance's own policies and procedures. 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 Sunrise as a provider of CST and IIH 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 Sunrise 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 Sunrise should be allowed to continue to provide these services until such time as Alliance determines that Sunrise 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