STATE OF NORTH CAROLINA	**THE OFFICE OF ADMINISTRATIVE HEARINGS**
COUNTY OF WAKE	**14 DHR 1594**

FIDELITY COMMUNITY SUPPORT GROUP, INC.,	)
Petitioner,	)
v.	)
ALLIANCE BEHAVIORAL HEALTHCARE, ***as legally authorized contractor of and agent for*** **N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES,**	)
Respondent.	)

FINAL DECISION

THIS MATTER came on for hearing before the undersigned, Donald W. Overby, Administrative Law Judge, on December 10, 2014 in Raleigh, North Carolina.

APPEARANCES

For Petitioner Fidelity Community Support Group, Inc. ("Petitioner" or "Fidelity")
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. Chapter 108C, Article 3 of N.C. Gen. Stat. Chapter 150B, and 42 C.F.R. § 438.214.

BURDEN OF PROOF

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

ISSUES

Petitioner Fidelity 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 Fidelity's ability to participate in the Community Support Team, Intensive In-Home and Substance Abuse Intensive Outpatient 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 Fidelity; 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 North Carolina 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

13. 1. 10A NCAC 22F .0101
14. 2. 10A NCAC 22F .0605
15. 3. Attachment 1.1B to the 1915(b) Waiver
16. 4. 42 C.F.R. §438.12
17. 5. 42 C.F.R. §438.214
18. 6. OAH Order in Family First v Alliance
19. 7. OAH Order in Essential Services v Alliance

20. 8. OAH Order in Miller v Alliance
21. 9. OAH Order in Yelverton's v PBH
22. 10. Superior Court Order in Cardinal v Derwin
23. 11. Superior Court Order in Yelverton's v PBH

Petitioner's Exhibits 2-11, 20-23, 26, 28, and 29 were allowed into evidence. These exhibits are:

2. Alliance's Summary of IIH RFP Review Scores for Fidelity Community
3. Fidelity Community's SAIOP Desk Review Clinical Score
4. Alliance CST RFP Desk Review Scoring Tool – Reviewer: Joe Corner
5. Alliance CST RFP Desk Review Scoring Tool – Reviewer: Alison Rieber
6. Alliance IIH RFP Desk Review Scoring Tool – Reviewer: Mary Ann
7. Alliance IIH RFP Desk Review Scoring Tool – Reviewer: Lori Caviness
8. Alliance SAIOP RFP Desk Review Scoring Tool – Reviewer: Vince Wagner
9. Alliance SAIOP RFP Desk Review Scoring Tool – Reviewer: Tina Howard
10. Alliance CST/IIH/SAIOP RFP Desk Review Scoring Tool – Reviewer: TH, NP, SP, MP
11. Alliance RFP 2013 Interview Questions for CST – Master Response Sheet
20. Fidelity Community's Proposal to Alliance for SAIOP services
21. Fidelity Community's Proposal to Alliance for CST services
22. Fidelity Community's Proposal to Alliance for IIH services
23. Email communications between Carlyle Johnson, Ph.D. (Alliance) and Dr. Okeke (Fidelity Community)
26. Alliance Board of Directors Agenda Action Form from 1/9/14 Board Meeting regarding Recommendations for Selection of Vendors for CST, IIH Services and SAIOP
28. NCDHHS Provider CABHA website article, "CABHAs: Critical Access Behavioral Health Agencies" – with Senate Bill 525, Session Law 2012-171
29. NC DMA Clinical Coverage Policy 8A, Enhanced Mental Health and Substance Abuse Services, Amended May 1, 2013

Petitioner's Exhibit For Judicial Notice

31. N.C. Gen. Stat. Ch. 108C – Medicaid and Health Choice Provider Requirements

Respondent's Exhibits 1-8, 12, 22-25 were allowed into evidence. These exhibits are:

1. Desk review scoring tool for executive summary and organizational background
2. Desk review scoring tool documents for Fidelity
3. 2013 Contract between Alliance and Petitioner
4. Three-month extension to 2013 contract between Alliance and Petitioner (through 3/31/14)
5. Non-renewal letter, Alliance to Petitioner re SAIOP and IIH dated December 13, 2013

6. Non-renewal letter, Alliance to Petitioner re CST dated January 10, 2014
7. Sign-in sheets for interview
8. Master Panel Response Sheet for Interview
12. Interview notes by Rose-Ann Bryda
22. Affidavit of Carlyle Johnson (*Exhibits are not attached but are on this list)*
23. Provider RFP Review Summary re IIH and SAIOP (desk review explanation)
24. 2014 Contract with Petitioner for non-RFP services
25. April 1, 2014 Contract Amendment with Petitioner following Preliminary Injunction Order

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

WITNESSES

Petitioner presented the testimony of:

1. Jim Okeke, CEO of Fidelity Community Support Group

Respondent presented the testimony of:

1. William Carlyle Johnson, employee of Alliance Behavioral Healthcare

Additional witnesses - Pursuant to the stipulations of the parties, all witness testimony in the related case, *Carolina Community Support Svcs. 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 witness who testified in Carolina Community are:

Petitioner:

1. Oswald Nwogbo, CEO of Carolina Community Support Svcs.
2. Lamar Marshall, employee of Carolina Community Support Svcs.

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 28, 2014, Petitioner Fidelity Community Support Group, Inc. ("Petitioner" or "Fidelity") 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. Fidelity 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 10, 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 Fidelity is a provider of mental health and behavioral health services with its principal place of business in Raleigh, North Carolina. Fidelity 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. Fidelity is a provider of Medicaid Intensive In-Home ("IIH") services, Community Support Team ("CST") services, and Substance Abuse Intensive Outpatient ("SAIOP") services in the Alliance catchment area. (Johnson, Vol. 1, p. 161; Okeke, Vol. 1, p. 209). These services are all Medicaid programs. (Johnson, Vol. 1, pp. 194-95).

3. Fidelity 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"). (Okeke, Vol. 1, p. 208). Fidelity must provide some combination of CST, IIH, or SAIOP services to continue to qualify as a CABHA. (Johnson, Vol. 1, pp. 186–87; Johnson Vol. 1, pp. 76–78).

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

5. Under federal and State law, the North Carolina Department of Health and Human Services ("DHHS") is the single State agency authorized by the federal government to administer the Medicaid program 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. (Johnson, Vol. 1, pp. 27–28, 176). Alliance's duties include authorizing and paying for recipient services, contracting with providers, and monitoring providers for compliance with regulatory and quality standards. (Johnson, Vol. 1, pp. 28–29, 138).

Federal, State, and Alliance Policy Requirements

8. The federal government has promulgated regulations that apply when states receive a waiver to operate Medicaid MCOs and PIHPs. One of these regulations is 42 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 an RFP, 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. (C.C. Pet. Ex. 12, p. 7). Only existing providers were allowed to submit a response and the RFP was closed to providers who were not currently operating in the Alliance network. (Johnson, Vol. 1, p. 28; Johnson, Vol. 1, p. 161).

16. Alliance contends that the reasons for the RFPs included that Alliance had excess capacity in its network and had concerns about quality of care; however, Alliance had no expectation regarding the number of existing providers that would be retained as a part of the RFP process. (Johnson, Vol. 1, p. 172; Johnson, Vol. 1, p. 168; Johnson, Vol. 2, p. 292; C.C. Pet. Ex. 12, p. 7). Prior to implementing the RFP process, Alliance conducted no study to determine if there were too many providers in the network. Alliance had no data indicating the number of providers that are needed for these three services in order to serve the Medicaid recipients in Alliance's service area. (Johnson, Vol. 1, p. 168).

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

18. Alliance released a separate RFP for each of the services. However, the contents of the RFPs were almost identical. (Johnson, Vol. 1, pp. 29–30; *compare* Jt. Exs. 6–8). 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. Fidelity met the established minimum requirements and was offered a three-month contract. Fidelity accepted and signed a contract with an ending date of March 31, 2014. (Respondent Exhibit 10). The three-month contracts offered by Alliance, including the one with Fidelity, 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 from 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, p. 5).

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. (C.C. Estes, Vol. 1, p. 105; Johnson, Vol. 1, pp. 40–42; C.C. Pet. Ex. 12, p. 1).

27. As part of this training, Alliance created a 14-page PowerPoint presentation. (C.C. Pet. Ex. 12; Johnson, Vol. 1, p. 216). The first 12 pages of the PowerPoint contain no information directing reviewers on how to judge or score a provider's RFPs during the Desk Review or Interview. (Johnson, T. Vol. 1, pp. 217–20; C.C. Pet. Ex. 12).

28. Page 13 is the only page in the entire PowerPoint that contains any guidance on how the reviewers should assign scores during the Desk Review and Interview. Page 13 contains a Likert Rating Scale that ranges from 1 to 5. (C.C. Pet. Ex. 12, 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. (Johnson, Vol. 1, pp. 226-27; C.C. Alston, Vol. 2, p. 501).

30. The RFP contained no information or guidance to reviewers indicating how the Likert Scores of 1–5 should be assigned. (Jt. Exs. 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*. at 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. (C.C. Estes, Vol. 1, p. 105; C.C. Pet. Ex. 12; 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." (C.C. 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. (C.C. 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. (C.C. 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; C.C. 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**.** (C.C. Rieber, Vol. 2, p. 423). Dr. Johnson testified that for CABHA medical directors the "preference is for psychiatrists." (Johnson, Vol. 1, p. 252). No such preference is expressed by Alliance in its RFPs. (Jt. Exs. 6–8).

Fidelity'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, pp. 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 Fidelity's RFP Responses passed the minimum criteria requirements and proceeded to the Desk Review. (Pet. Ex. 2, p. 1).

The RFP Desk Review

37. The second step of the RFP process consisted of a Desk Review of the provider's written RFP Response. (Johnson, Vol. 1, p. 33). At the Desk Review stage, several individuals

were assigned to review and score specific sections of the providers' written responses, which were given different weights when the Desk Review Score was assigned. (Johnson, Vol. 1, pp. 218–219). The RFP sections scored by Alliance in the Desk Review included: the Executive Summary (5%); Organizational Background (10%); Clinical Programing and Response to Scope of Work (50%); Legal and Compliance Information (10%); Financial Information (20%); and Technological Capability (5%). (Johnson, Vol. 1, pp. 31–32; C.C. Pet. Ex. 12, p. 10; Jt. Ex. 6, 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 Programing Section of the Desk Review two individuals reviewed the written response and provided scores for each of seven categories. The scores for the seven categories were averaged to determine the Clinical Programing Score and Alliance used the highest average score as the provider's Clinical Programing score for the Desk Review. (Johnson, Vol. 1, p. 220).

39. If the provider scored 65% or higher on the Desk Review, the provider proceeded to the final stage of the RFP process. (Johnson, Vol. 1, pp. 33–34). At the Desk Review portion of the process, Fidelity received a score of 59.7% for the IIH review and 61.9% for the SAIOP review. (Pet. Ex. 2, p. 1). Thus, Fidelity did not qualify for an interview in these two services.

40. Alliance did not provide Fidelity with any information regarding the score it received in the CST Desk Review and failed to provide any testimony or evidence regarding Fidelity's CST Desk Review score. However, it is undisputed that Fidelity received a Desk Review score in excess of 65 percent for its CST Desk Review because it advanced to the interview stage of the RFP process for CST. (Johnson, Vol. 1, p. 95).

41. 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 Fidelity's SAIOP review, the reviewers disagreed in four of the seven Clinical Review categories. (Pet. Ex. 3, p. 3, Chart of Scores). In one instance, the reviewers found that for the same question Fidelity's response deserved a 4 ("good," "strong," "well-planned," and "clear") while the other reviewer found that the response deserved a 2 ("minimal," "weak," and "confusing"). (*Id*.). Similarly, for Fidelity's IIH Desk Review, the reviewers' scores were different in five of the seven clinical review criteria, including another instance where a reviewer assigned a score of 2 and the other reviewer assigned a score of 4 for the same question. (Pt. Ex. 3, p. 3, Chart of Scores).

42. The evidence demonstrates that variation in scoring was systemic. In the Carolina Community's CST Desk Review, one reviewer, Allison Rieber, gave Carolina Community a score of 4 for Clinical Questions 2–4. (C.C. 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 the scores, Ms. Estes testified that the difference was the result of the fact that she and Ms. Rieber had "different backgrounds and experiences." (C.C. Estes, Vol. 1, p. 151).

43. 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. (C.C. Estes, Vol. 1, p. 151). As evidenced by the

wide variation in the scores 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.

44. Merely averaging the divergent scores 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.

45. Dr. Johnson was not clear on the total number of reviewers that participated in the RFP process, but thought it was around ten. (Johnson, Vol. 2, p. 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. 314-15). 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.

Alliance Incorrect Calculation of Fidelity's Desk Review Scores

46. The SAIOP score recorded by Alliance for Fidelity's Desk Review was 61.9%, and, as a result, Fidelity did not move forward to the interview stage of the RFP process. (Pet. Ex. 2, p. 1; Johnson, Vol. 1, p. 10). Alliance made a mathematical error when it calculated Fidelity's SAIOP Desk Review score. (Johnson, Vol. 1, pp. 29–43; Pet. Ex. 3, p. 1).

47. If Alliance would have calculated Fidelity's SAIOP Desk Review score correctly for the Clinical Review score, Fidelity would have received a Desk Review score of 65.4% and moved on to the interview stage of the RFP. (*Id.*). Alliance's decision to terminate Fidelity's participation in the Medicaid SAIOP program was based on a mathematical error and is therefore erroneous and invalid.

48. Alliance also incorrectly calculated Fidelity's IIH Desk Review score. (Johnson, Vol. 1, pp. 29-43; Pet. Ex. 3, p. 2). If Alliance had properly calculated Fidelity's IIH Desk Review score, it would have resulted in a score of 62.6%, and not 59.9%. (Pet. Ex. 3, p. 2; Johnson, Vol. 1, pp. 56–57).

Alliance's Scoring of Non-Clinical Sections of the RFP Desk Review

49. Fidelity's Desk Review scores for SAIOP and IIH also contain inconsistencies in areas outside of the clinical review. Unlike the Clinical Review, where two reviewers assigned scores, the review of the Non-Clinical sections of Fidelity's written response was conducted by only one person. (Res. Ex. 1).

50. Organizational Background was one of the scored sections of the Desk Review and accounted for 10% of the total Desk Review Score. (Johnson, Vol. 1, p. 31; C.C. Pet. Ex. 12, p. 10; Jt. Ex. 6, p. 13). Fidelity received a score of 3 for its Organizational Background response. (Pet. Ex. 2, p. 1). This means that its response was sufficient, but some questions and concerns remained. (Res. Ex. 1, p. 3).

51. The reviewer listed as its justification for assigning score of 3 in for Organizational Background the fact that it took Fidelity four years to go from 25 to 100 consumers, that the backgrounds of staff were provided in two to three sentences and no resumes were included, and that Fidelity does not have a board of directors. (Res. Ex. 1, p. 3).

52. As to the first justification, the rate of Fidelity's growth bears no relation to Fidelity's Organizational Background. The information requested by Alliance in the Organizational Background section of the RFP does not ask the provider to include its growth rate.

It also includes no indication that an organization's growth rate should have any bearing on how the provider will be scored in this category. (Jt. Exs. 6–8, p. 7).

53. As for the justification that Fidelity only included two to three sentences about key staff and no resumes were included in the written response, the RFP requested the provider to "identify your owners, Medical Director, Clinical Director, QM/Training Director and other key management staff including background (e.g. education, previous agencies, mental health experience etc.)." (Jt. Ex. 6, p. 7).

54. A review of Fidelity's response to this question demonstrates that it provided the information requested by the RFP by providing the educational experience, mental health experience, significant mental health trainings, and the licensure status of its key staff. (Pet. Ex. 21, p. 5). Further, Alliance admitted that it did not request resumes in the organizational background section of the RFP. (Johnson, Vol. 1, p. 66; Jt. Ex. 6, p. 7).

55. The RFP also contains no preference or requirement that a provider have a Board of Directors. (Jt. Ex. 6, pp. 2, 5). Dr. Johnson conceded that it was "fine" for a provider not to have a Board of Directors but that what Alliance really wanted to know from this question is "how the organization was run." (Johnson, Vol. 1, p. 72). The question in the RFP, however, does not ask the provider to explain how its organization is run but instead asks the provider to identify its Board of Directors by name, indicate the term of office, provide the home and business address of each board member and state if the board member is an officer agent or employee. (Jt. Ex. 6, p. 7). Dr. Johnson's testimony provides another example where the expectations of Alliance were based on a subjective "interpretation" of the RFP that bears no relation to the information requested.

56. Even accepting Dr. Johnson's testimony that providers should have given information about how "the organization was run" in response to this very straightforward question, Fidelity did just that stating: "At present, Fidelity does not operate with a board of directors. The Clinical Director manages the clinical aspect of the agency. The Medical Director oversees the medical aspect of the agency, as well as validates the necessity of the services offered. The CEO acts as the Executive Director." (Pet. Ex. 21, p. 6). Although it would have been sufficient for Fidelity to simply state that it had no Board of Directors, Fidelity provided additional information to identify the individuals that managed certain aspects of its business.

57. In the RFP, providers were asked to provide specific information regarding their organizational structure. (Jt. Exs. 6–8, p. 7). The Organizational Structure questions were fact-based requests. Providers either provided the information or did not provide the information requested. Fidelity responded fully to the information requested in the Organizational Background section of the RFP. (Johnson, Vol. 1, pp. 62–65).

58. Alliance's justifications for a score of 3 in this section of the RFP demonstrate that the reviewer substituted her preferences and applied nonexistent criteria in determining the score for Organizational Background section of the Desk Review. It is inappropriate for reviewers to substitute their individual preferences when assigning scores to an RFP response (Johnson, Vol. 2, p. 328).

59. Alliance could not explain why Fidelity received a score of 3 instead of a score of 4 in this section of the RFP and could not identify any legitimate questions or concerns the reviewer might have had for Fidelity's response to this section of the RFP. (Johnson, Vol. 1, pp. 71–75).

60. Because Fidelity answered the question fully and there were no legitimate questions that should have been raised from Fidelity's response, Fidelity should have received at least a score of 4 in this section under Alliance's scoring system. If Fidelity would have received a score of 4 in this section of the Desk Review, it would have proceeded to the interview round of the RFP

review for both SAIOP and IIH, the mathematical error notwithstanding. (Res. Ex. 3, pp. 2–3; Johnson, Vol. 1, p. 76).

61. Based on the Findings of Fact above, Alliance erred and acted arbitrarily and capriciously in deciding that Fidelity's IIH and SAIOP programs should not advance to the interview stage of the RFP process, which had the effect of terminating Fidelity from these Medicaid programs.

The RFP Interview Process

62. 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. (C.C. Pet. Ex. 12). The individuals that made up the provider interview panel varied from provider to provider. (Johnson, Vol. 1, p. 41; Vol. 2, pp. 314–15).

63. 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 the provider interviews. (Johnson, Vol. 1, pp. 224–25; C.C. Estes, Vol. 1, pp. 101–2).

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

65. 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.

66. 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.

67. 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).

68. 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. (C.C. Estes, Vol. 1, pp. 137–38; Johnson, Vol. 2, p. 314).

69. Alliance did no further review of the scores assigned by the different interview panels to determine if the interview scores were consistent. (Johnson, Vol. 2, pp. 330–31). It is problematic that no attempt was made to review or standardize the interview scores because the evidence shows that Alliance learned during the Desk Review process that its reviewers had different understandings regarding what was required by the RFP and that the scores were largely determined by the skills and experience of the reviewers and not by the application of objective criteria.

Fidelity's CST Interview Score

70. Fidelity proceeded to the interview stage of the RFP process for its CST service. (Johnson, Vol. 1, p. 95). Unlike in Carolina Community, Alliance did not provide Fidelity with a

document containing the justifications for its CST interview scores. (Okeke, Vol. 1, p.182; *see also* C.C. Pet. Ex. 1).

71. Shortly after Fidelity learned that it would be terminated from the CST program based on its interview score, Dr. Okeke sent Alliance an email requesting that it provide Fidelity with documentation outlining the reasons for Alliance's decision. (Pet. Ex. 23; Johnson, Vol. 1, p. 98; Okeke, Vol. 1, p. 182). Dr. Johnson informed Dr. Okeke that he would send him the document. No such document was ever created or sent to Fidelity by Alliance (Pet. Ex. 23; Johnson, Vol. 1, pp. 96–99; Okeke, Vol. 1, p. 182).

72. The only document in the record containing Fidelity's CST interview score is the interview panel's master form, which reflects the notes taken by the interview note-taker and the score assigned by the interview panel for each of the nine questions asked by the panel. (Pet. Ex. 11). This document does not set forth Alliance's total interview score and there is no evidence in the record setting forth Fidelity's final CST interview score, indicating how close Fidelity came to meeting the 55% score requirement.

73. In *Carolina Community*, Alliance tendered several witnesses that served as reviewers for Carolina Community's interview panel. (*See* C.C. Vol. 1, Testimony of A. Rieber, C. Estes; Vol. 2, M. Johnson). Alliance represented at the start of the Fidelity hearing that it would call five reviewers that participated in Fidelity's RFP review, including two witnesses that participated in the Fidelity interview (Opening Statement, Vol. 1, p. 7). During the testimony of Carlyle Johnson, Alliance's counsel stated that "rather than go through all these details, since I've got some witnesses coming up, I'll forego further questions about the interview – and address those in some of the other witnesses." (Johnson, Vol. 1, pp. 27–28). However, the record shows that Alliance rested its case after the testimony of Carlyle Johnson and presented no testimony from any of the five reviewers it indicated it would call as witnesses, including the two reviewers that participated in the interview. (Johnson, Vol. 1, p. 28).

74. During the direct testimony of Dr. Johnson, he provided no reason or justification for why Alliance determined that Fidelity's CST responses were insufficient to remain as a provider in its network. (Johnson, Vol. 1, pp. 26–28). During his cross examination, when asked why certain scores were assigned by Alliance for the interview review stage, Dr. Johnson repeatedly deferred to the panel and stated that he did not know why certain scores were assigned because he did not participate in the interview. (Johnson, Vol. 1, pp. 103, 118–20, 125, 136, 138, 140, 142, 144–45).

75. Respondent has the burden of proof in this case. Respondent provided no exhibit setting forth the justification for its scores in Fidelity's CST review and the testimony provided by Dr. Johnson demonstrates that he lacked knowledge and consistently deferred to the reviewers when discussing the basis for this decision.

76. Based on the above Findings of Fact, because Alliance chose not to provide any documentary evidence or testimony to explain the basis for its CST interview decision, Alliance has not met its burden of proof. Alliance's decision regarding Fidelity's CST program was therefore erroneous.

77. While Alliance provided no evidence regarding the basis or justification for the scores it assigned, the record does contain the questions that were asked during the interview as well as the notes of the recorder indicating "panel feedback" or "panel comments" for seven of the nine questions. (Res. Ex. 11). The interview recorder's notes and the testimony of Dr. Johnson and Dr. Okeke, do serve to provide insight into Fidelity's interview.

Question 1 – Organizational Strengths

78. The first interview question asked of the provider is to briefly describe the strengths of the organization. (Res. Ex. 11, p. 1). Fidelity received a score of 2.5 for this question. The panel feedback for this question indicates that the provider noted that they had a crisis phone line as something that sets them apart and that it was not clear who Fidelity partners with. (*Id*.).

79. Dr. Johnson speculated that the interview panel likely felt that it was a cause for concern that Fidelity touted its crisis line as something that set them apart, since all providers are required to have a crisis phone line. (Johnson, Vol. 1, p. 100).

80. The evidence shows, however, that Fidelity's crisis phone line is always staffed by a licensed individual and that most providers staff their crisis phone lines by using a call center that employs non-licensed individuals. (Okeke, Vol. 1, p. 183). In answering the question, Fidelity felt that its crisis phone service set it apart from other providers because it allows them to respond to crises much quicker than if the phone line is staffed with an individual who is not licensed. (*Id*.). By having a licensed clinician answer crisis calls, Fidelity is able to immediately begin providing crisis services without down time or the transition required to locate a licensed individual when a non-licensed individual answers a crisis call. (*Id*.). The evidence thus shows that it was appropriate for Fidelity to mention its crisis phone service as something that sets it apart from other providers.

81. As to the "panel feedback" indicating that the panel was unsure of the agencies that Fidelity partners with, the interview notes indicate that Fidelity felt its community relationships were strong and Fidelity listed several agencies and groups that it works with in the community. (Johnson, Vol., 1, p. 101; Okeke, Vol. 1, p. 185; Pet. Ex. 11). Further, the provider was asked what sets it apart from other providers—not to list and describe the agencies that it partners with. (Pet. Ex. 11). While an agency response may include such information if it believes that sets it apart, the fact that the panel feedback indicates that the reviewers were looking for such information reveals that the interview panel failed to understand the scope of the question.

82. Based on these comments and the evidence in the record, the interview panel erred when it assigned a score of 2.5 in the Agency Strength category of the interview.

Question 2 – Medication Management and Psychiatric Services

83. The second question asked at the interview was, "[D]oes your agency have access to medication management and psychiatric services within the local community? Does your agency have access to tele-psychiatry services?" (Pet. Ex. 11). The interview notes indicate that Fidelity is providing Medication Management to half of its consumers, and that both Wake and Durham consumers are served at its RTP office. Fidelity also stated that they have a child psychiatrist and a psychiatric nurse practitioner but are not currently providing tele-psychiatry. (*Id*.).

84. The panel feedback listed in the recorder's notes is that it was "not clear how many clients Fidelity is actually serving" or "how many hours of medication management is being provided." In the notes to the first question, the note-taker documented that Fidelity stated it was currently serving 140 consumers. (*Id*.). Additionally, the RFP sets forth no requirement or preference for the number of medication management hours that should be provided. It seems to the Undersigned that the number of Medication Management hours provided would not be a relevant metric since it would vary from agency to agency depending on how many consumers needed Medication Management. What is clear from the notes is that Fidelity is providing a significant amount of medication management.

85. Based on the above, there is no justification for a score of 3 in this category as there was no legitimate questions or concerns that should have remained based on Fidelity's response to the question asked.

Question 3 – CABHA Medical Director and Availability of Psychiatric Services

86. Question 3 asks the provider to "describe the role of your medical director . . . how much time is provided for administrative oversight versus direct patient care? Is direct supervision provided to medical staff or other clinical staff?" (Pet. Ex. 11). Fidelity received a score of 2 for this question. (*Id*.).

87. Fidelity answered that their medical director is allotted between 5 and 8 hours of administrative only time and that he was a licensed family physician. Fidelity stated the medical director does not provide direct care but it has contracted with a child psychiatrist who provides no less than 15 hours a month of direct medical services and a psychiatric nurse practitioner who provides no less than 20 hours a month of direct medical services. (Res. Ex. 11).

88. The panel feedback was that the medical director was a family practitioner, and was not board certified. It also states that the medical director had low hours and does not see patients. (Pet. Ex. 11). Under the CABHA statute, there is no requirement for the number of hours that a medical director provides. (Pet. Ex. 28; Johnson, Vol. 1, pp. 108–09). Medical directors are also not required to provide direct care and can oversee other medical professionals. (Johnson, Vol. 1, p. 108). Dr. Johnson testified that if a provider met state requirements it should receive at least a score of 3. (Johnson, Vol. 1, pp. 253–55).

89. Alliance contends that its RFP had a preference that the medical director be contracted to provide at least 10 hours of services. The RFP does not state that the medical director must provide 10 hours of administrative services. (Johnson, Vol. 1, pp. 112–13, 117). In Fidelity's case, it has a medical director that provides five to eight hours of administrative oversight, and a psychiatrist who provides an additional 15 hours of physician services. (Res. Ex. 11, pp. 1–2). In total, Fidelity has two licensed physicians that provide at least 43 hours per month of administrative and direct care services.

90. According to Dr. Johnson, he did not believe that the fact that the medical director was a family practitioner was the basis for the score of 2, but could not answer why the interview panel noted that the medical director was a family practitioner if that was not a factor in its decision. (Johnson, Vol. 1, pp. 119, 122). Alliance concedes that the fact that the Medical Director was a family practitioner would not justify a low score. (Johnson, Vol. 1, p. 118).

91. Based on the above Findings of Fact a score of 2 in this category is erroneous.

Question 4 – Staffing for Services

92. In Question 4 Fidelity was asked to "describe how it staffed for services? Are they contractors or employees, and how do you cover staff vacancies? (Pet. Ex. 11, p. 2). Fidelity received a score of 2 for Question 4. (*Id*.). The panel comment for this question is "unclear status of staff, all are reported as contractors, but they can request to be full time, intermingling staff across services." (*Id*.).

93. The RFP contains no requirement that staff cannot be contract employees. The RFP also states no preference between contractors or full-time employees. (Jt. Ex. 7, pp. 2, 5). The panel comments also state that Fidelity intermingles staff across services. Clinical coverage policy allows staff to be shared across services, as long as each team has full-time equivalent for the team lead position. (Pet. Ex. 29, p. 36; Johnson, Vol. 1, pp. 80–81). Alliance admitted that Fidelity answered the question that was asked of it in this category. (Johnson, Vol. 1, pp. 133–

35). Despite providing the information requested, Fidelity received a score of 2 for reasons that went beyond the question.

94. For this question the note taker indicated that Fidelity stated that its team leaders were all licensed professionals. The RFP states that a preference would be given to those providers that employ only licensed professionals as Team Leaders. (Jt. Ex. 7, p. 2). Based on the score assigned, the interview panel failed to consider this preference when it assigned a score of 2 to Question 4.

95. Based on the Findings of Fact above, the score of 2 for this category is erroneous.

Question 5 – Evidenced Based Practices

96. Question 5 involved Fidelity's use of evidence-based practices. Fidelity scored a 2.5 for this question. (Pet. Ex. 11, pp. 2–3). The panel comments state it is unclear whether all staff had trainings or MINT training. This information provided in the RFP response demonstrated that Fidelity's staff had all required training. More telling, the note taker documented Fidelity specifically stated during the interview that "staff are also trained in MI, we use a MINT-certified trainer. This is a requirement before beginning work." (Pet. Ex. 11, p. 3). The panel comments, therefore, are totally disconnected to the response given by Fidelity. Fidelity made very clear that it used a MINT-certified trainer in its response. Based on the panel comments, the score of 2 cannot be justified for this category.

Question 6 – Transitioning to Alternative Levels of Care

97. For question 6, Fidelity was asked what would trigger it to update a consumer's assessment and consider an alternative level of care. Fidelity received a score of 3 for this question. (Pet. Ex. 11, p. 3). Fidelity provided an answer which included what would trigger a move of its clients to a higher level of care, as well as the factors it considers when stepping a client down to a lower level of care. (*Id*.).

98. The panel comments appear to ignore the response given by Fidelity and state that Fidelity only addressed referring clients to higher levels of care when the panel's notes document that Fidelity addressed referring consumers to both higher and lower levels of care. (Johnson, Vol. 1, pp. 141–42).

Question 7 – Capacity for Transitioned Consumers

99. Question 7, asked providers to "describe your capacity and plan for acceptance of transitioned consumers?" Fidelity indicated in its response that it was wide open, would like to move to a bigger facility, is recruiting additional employees, QP and licensed therapists, that they were ready to establish a satellite office. A score of 2.5 was assigned to this category. (Pet. Ex. 11, p. 3). Alliance provides panel comments to justify why a score of 2.5 was appropriate.

100. Based on the question that was asked, Fidelity fully answered the question and a score of 2.5 was not justified for this question.

Question 8 – Diverse Populations and Agency Partnerships

101. Question 8 involves Fidelity's ability to work with diverse populations and agency partnerships. Fidelity received a score of 2 in for this question. (Pet. Ex. 11, p. 4).

102. Fidelity indicated in response that a majority of its consumers were African American and that it recognized the need to be culturally sensitive. Fidelity stated they had seen a high number of referrals in the Hispanic population and was working with El Centro, an Hispanic advocacy group, in its community. It also stated it worked with DSS and that cultural perspectives were respected. Fidelity has hired a bilingual person for its staff. (Pet. Ex. 11, p. 4; Johnson, Vol. 1, pp. 143–44).

103. Alliance's interview notes provide no feedback or comments for why a score of 2 was assigned to this question. (Pet. Ex. 11, p. 4). However, Fidelity fully answered this question and there is nothing in the RFP criteria or the clinical coverage policy criteria which would indicate this answer deserves a score of 2.

Question 9 – Complaints and Grievances

104. The final question asked Fidelity to "tell us about complaints and grievances, what have you learned through the review and what would you do different?" (Pet. Ex. 11, p. 4). Fidelity received a score of 1 for this question. (*Id.*).

105. Fidelity answered that it had not had any complaints with the MCO or the State, but it tries to address issues with staff directly when there are internal complaints. Fidelity discussed its grievance process and the forms and procedures it had created. Fidelity further indicated that when there had been internal complaints, the clinical director has been able to address those complaints at the staff level. Fidelity has not lost a consumer to another agency due to dissatisfaction with the service. Fidelity had also done a survey audit to determine how they can update and implement changes into their day-to-day practice. The only question listed in the interview panel notes is that Fidelity did not say what its client survey revealed and what it did to address issues revealed in the survey. (Pet. Ex. 11, p. 4).

106. Based on Fidelity's response and the single question documented in the interview panel's notes, a score of 1 was not justified.

107. Based on the Findings of Fact above, and putting aside the fact that Alliance did not put on any testimony or documentary evidence regarding its justification for determining that Fidelity should have been terminated from the CST program, the evidence in the record demonstrates that Fidelity's CST interview score was erroneous and arbitrary and capricious.

Federal Requirements for Retention of Providers

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

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

110. Alliance contends that Alliance, at its sole discretion, can renew a contract or let it expire. (Johnson, Vol. 2, p. 368, 370; c.c. Res. Ex. 21, p. 6). If a contract expires, the provider can no longer participate in that Medicaid program. (Johnson, Vol. 1, p. 195). 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.

111. 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."

112. 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 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.

113. 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

114. 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).

115. 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).

116. 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).

117. 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.

118. As a CABHA in the Alliance network, Fidelity must provide IIH, CST, or SAIOP in order to continue to be a CABHA. (Johnson, Vol. 1, pp. 186–87; Johnson Vol. 1, pp. 76–78). Thus, Alliance's RFP decision determined whether Fidelity would be maintained or terminated as an agency-based Medicaid provider.

119. 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.

120. 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

121. 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).

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

123. 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).

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

125. 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 Fidelity would be retained. (Johnson, Vol. 1, pp. 207-08).

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

127. 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. (C.C. Res. Ex. 21, p. 6).

128. 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.

129. 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.

130. Dr. Johnson stated that as a closed network "Alliance is not required to admit any provider into the network once we have sufficient providers in the network." (Johnson, Vol. 1, p. 29). This case, however, is not about admitting providers in the network. Fidelity is already a

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

131. 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).

132. 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).

131. 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, Fidelity 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.

132. 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.

133. 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 Fidelity's termination. (*Id.*).

134. One of the conditions in Alliance's provider retention policy for nonrenewal is if Alliance issues an RFP, RFI. (*Id.*, p. 38). However, its policy does not state that if Alliance issues an RFP it can ignore its 17 provider retention factors when it creates the RFP review criteria. 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, pp. 92–95, Attachment O).

Alliance's RFP Procedures

135. 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*.).

136. 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 Community and Family Advisory Committee ("CFAC") 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).

137. 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).

138. 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. (C.C. Pet. Ex. 12, p. 13).

139. 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.

140. In addition, the DMA Contract requires Alliance to base its decision on the demonstrated performance of the agency. (Jt. Ex. 4, p. 2, Attachment O). A provider's past compliance record would have provided valuable information to the interview panel about the demonstrated performance of the agency. There is no evidence in the record that Fidelity has had any compliance issues for these services.

141. 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).

142. 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 Fidelity interview panel had assigned scores based on criteria not found in the RFP, the clinical coverage policy, or any other policies or requirements.

Providers Selected by the RFP Process

143. 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.

144. At the expiration of those contracts, the providers that were selected through the RFP process were all provided contract extension into 2015 if they continued to provide and bill Alliance for the service. (Johnson, Vol. 1, p. 258; Johnson, Vol. 1, p. 155–156). In determining whether providers that received an RFP as a result of this process were able to continue to provide services in 2015, Alliance did not conduct another RFP. (Johnson, Vol. 1, p. 156). Instead, the standards used to determine if these providers were able to continue to provide these services was

whether they met Alliance's retention criteria. (*Id.*). The only way a contract would not have been extended into 2015 is if the provider had a serious compliance issue. (Johnson, Vol. 1, p. 258).

145. Fidelity has continued to provide services pursuant to a stay issued by this Court. (Johnson, Vol. 1, p. 26; Res. Ex. 25). Alliance has had no compliance issue during this time period. Under the criteria set forth by Alliance, if Fidelity would have been awarded a contract extension under the RFP, it would still be allowed to provide services in 2015.

146. Dr. Johnson testified that if this Court found that Alliance's RFP process and the scores assigned were erroneous and in violation of the law and Alliance's policies that Alliance had no other reason not to want to contract with Fidelity. (Johnson, Vol. 1, pp. 174–75). He further testified that if this was the case, Fidelity should be treated as any other provider that made it through the RFP process. (*Id.*).

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

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

CONCLUSIONS OF LAW

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

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

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

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

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

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

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

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

7. 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 right recognized in *Bowens* and *Ram*.

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

10. Alliance's contention that Carolina Community was not really terminated since they can participate in Alliance's network in ways other than providing CST, IIH, and SAIOP

services, as well as continuing as a CABHA, is without merit. Carolina Community is being terminated from providing those services.

11. Alliance's contention that providers have no right to challenge Alliance's termination is therefore without merit given that the General Assembly has specifically given providers a right to contest a termination decision at OAH. If Alliance's position was 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 Fidelity 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 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 Fidelity and every other provider in its network only exists because of the Medicaid waiver. (Johnson, Vol. 1, pp. 28-29). 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. 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.

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 § 1396(a)(10)(B)).

30. Alliance's contention that its decision to not renew Fidelity'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 and failed to act as required by law or rule. N.C. Gen. Stat. § 150B-23(a).

32. Regarding Fidelity'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, Fidelity should have received a passing interview score. Alliance has exceeded its authority, acted erroneously, and failed to act as required by law or rule. N.C. Gen. Stat. § 150B-23(a).

33. Under relevant North Carolina case law, decisions are arbitrary or capricious if they are "patently in bad faith, or whimsical in the sense that they indicate a lack of fair and careful consideration or fail to indicate any course of reasoning and the exercise of judgment." *Lewis v. N.C. Dep't. of Human Res.,* 92 N.C. App. 737, 740, 375 S.E.2d 712, 714 (1989) (emphasis added).

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

35. Based on the Findings of Fact, there is no basis for Alliance to terminate Fidelity's participation in these Medicaid program and ability to operate as an agency-based CABHA provider in the Alliance network. Fidelity should have received passing desk review and interview scores. 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. Further, in the desk review Alliance erred in the manner it calculated Fidelity's SAIOP and IIH scores.

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

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

DECISION

NOW, THEREFORE, based on the foregoing Findings of Fact and Conclusions of Law, the Undersigned determines that Respondent substantially prejudiced Petitioner's rights, acted outside its authority, acted erroneously, acted arbitrarily and capriciously, used improper procedure, and failed to act as required by law or rule in its decision to terminate Fidelity as a provider of CST, IIH, and SAIOP services in the Alliance service area. The Undersigned also finds that the RFP process itself violated procedure and law and was arbitrary and capricious in its design and implementation. Respondent's decision is hereby **REVERSED**.

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

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

NOTICE

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

This the 2nd day of April, 2015.

_____

Donald W. Overby
Administrative Law Judge