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The Office of Administrative Hearings
Rules Division
6714 Mail Service Center
Raleigh, NC 27699-6714
Telephone (919) 431-3000
Fax (919) 431-3104

Julian Mann III, Director
Molly Masich, Codifier of Rules
Dana Vojtko, Publications Coordinator
Lindsay Woy, Editorial Assistant
Kelly Bailey, Editorial Assistant

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Contact List for Rulemaking Questions or Concerns

For questions or concerns regarding the Administrative Procedure Act or any of its components, consult with the agencies below. The bolded headings are typical issues which the given agency can address, but are not inclusive.

Rule Notices, Filings, Register, Deadlines, Copies of Proposed Rules, etc.

Office of Administrative Hearings
Rules Division
1711 New Hope Church Road (919) 431-3000
Raleigh, North Carolina 27609 (919) 431-3104 FAX

contact:	Molly Masich, Codifier of Rules	molly.masich@oah.nc.gov	(919) 431-3071
	Dana Vojtko, Publications Coordinator	dana.vojtko@oah.nc.gov	(919) 431-3075
	Lindsay Woy, Editorial Assistant	lindsay.woy@oah.nc.gov	(919) 431-3078
	Kelly Bailey, Editorial Assistant	Kelly.bailey@oah.nc.gov	(919) 431-3083

Rule Review and Legal Issues

Rules Review Commission
1711 New Hope Church Road (919) 431-3000
Raleigh, North Carolina 27609 (919) 431-3104 FAX

contact:	Abigail Hammond, Commission Counsel	abigail.hammond@oah.nc.gov	(919) 431-3076
	Amber Cronk May, Commission Counsel	amber.may@oah.nc.gov	(919) 431-3074
	Amanda Reeder, Commission Counsel	amanda.reeder@oah.nc.gov	(919) 431-3079
	Julie Brincefield, Administrative Assistant	julie.brincefield@oah.nc.gov	(919) 431-3073
	Alexander Burgos, Paralegal	alexander.burgos@oah.nc.gov	(919) 431-3080

Fiscal Notes & Economic Analysis and Governor's Review

Office of State Budget and Management
116 West Jones Street (919) 807-4700
Raleigh, North Carolina 27603-8005 (919) 733-0640 FAX
Contact: Anca Grozav, Economic Analyst osbmruleanalysis@osbm.nc.gov (919) 807-4740

NC Association of County Commissioners
215 North Dawson Street (919) 715-2893
Raleigh, North Carolina 27603
contact: Amy Bason amy.bason@ncacc.org

NC League of Municipalities (919) 715-4000
215 North Dawson Street
Raleigh, North Carolina 27603
contact: Sarah Collins scollins@nclm.org

Legislative Process Concerning Rule-making

Joint Legislative Administrative Procedure Oversight Committee
545 Legislative Office Building
300 North Salisbury Street (919) 733-2578
Raleigh, North Carolina 27611 (919) 715-5460 FAX

contact:	Karen Cochrane-Brown, Staff Attorney	Karen.cochrane-brown@ncleg.net
	Jeff Hudson, Staff Attorney	Jeffrey.hudson@ncleg.net

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NORTH CAROLINA REGISTER
Publication Schedule for January 2015 – December 2015

FILING DEADLINES			NOTICE OF TEXT		PERMANENT RULE			TEMPORARY RULES
Volume & issue number	Issue date	Last day for filing	Earliest date for public hearing	End of required comment Period	Deadline to submit to RRC for review at next meeting	Earliest Eff. Date of Permanent Rule	Delayed Eff. Date of Permanent Rule 31st legislative day of the session beginning:	270th day from publication in the Register
29:13	01/02/15	12/08/14	01/17/15	03/03/15	03/20/15	05/01/15	05/2016	09/29/15
29:14	01/15/15	12/19/14	01/30/15	03/16/15	03/20/15	05/01/15	05/2016	10/12/15
29:15	02/02/15	01/09/15	02/17/15	04/06/15	04/20/15	06/01/15	05/2016	10/30/15
29:16	02/16/15	01/26/15	03/03/15	04/17/15	04/20/15	06/01/15	05/2016	11/13/15
29:17	03/02/15	02/09/15	03/17/15	05/01/15	05/20/15	07/01/15	05/2016	11/27/15
29:18	03/16/15	02/23/15	03/31/15	05/15/15	05/20/15	07/01/15	05/2016	12/11/15
29:19	04/01/15	03/11/15	04/16/15	06/01/15	06/22/15	08/01/15	05/2016	12/27/15
29:20	04/15/15	03/24/15	04/30/15	06/15/15	06/22/15	08/01/15	05/2016	01/10/16
29:21	05/01/15	04/10/15	05/16/15	06/30/15	07/20/15	09/01/15	05/2016	01/26/16
29:22	05/15/15	04/24/15	05/30/15	07/14/15	07/20/15	09/01/15	05/2016	02/09/16
29:23	06/01/15	05/08/15	06/16/15	07/31/15	08/20/15	10/01/15	05/2016	02/26/16
29:24	06/15/15	05/22/15	06/30/15	08/14/15	08/20/15	10/01/15	05/2016	03/11/16
30:01	07/01/15	06/10/15	07/16/15	08/31/15	09/21/15	11/01/15	05/2016	03/27/16
30:02	07/15/15	06/23/15	07/30/15	09/14/15	09/21/15	11/01/15	05/2016	04/10/16
30:03	08/03/15	07/13/15	08/18/15	10/02/15	10/20/15	12/01/15	05/2016	04/29/16
30:04	08/17/15	07/27/15	09/01/15	10/16/15	10/20/15	12/01/15	05/2016	05/13/16
30:05	09/01/15	08/11/15	09/16/15	11/02/15	11/20/15	01/01/16	05/2016	05/28/16
30:06	09/15/15	08/24/15	09/30/15	11/16/15	11/20/15	01/01/16	05/2016	06/11/16
30:07	10/01/15	09/10/15	10/16/15	11/30/15	12/21/15	02/01/16	05/2016	06/27/16
30:08	10/15/15	09/24/15	10/30/15	12/14/15	12/21/15	02/01/16	05/2016	07/11/16
30:09	11/02/15	10/12/15	11/17/15	01/02/16	01/20/16	03/01/16	05/2016	07/29/16
30:10	11/16/15	10/23/15	12/01/15	01/15/16	01/20/16	03/01/16	05/2016	08/12/16
30:11	12/01/15	11/05/15	12/16/15	02/01/16	02/22/16	04/01/16	05/2016	08/27/16
30:12	12/15/15	11/20/15	12/30/15	02/15/16	02/22/16	04/01/16	05/2016	09/10/16

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EXPLANATION OF THE PUBLICATION SCHEDULE

This Publication Schedule is prepared by the Office of Administrative Hearings as a public service and the computation of time periods are not to be deemed binding or controlling. Time is computed according to 26 NCAC 2C .0302 and the Rules of Civil Procedure, Rule 6.

GENERAL

The North Carolina Register shall be published twice a month and contains the following information submitted for publication by a state agency:

(1) temporary rules;
(2) text of proposed rules;
(3) text of permanent rules approved by the Rules Review Commission;
(4) emergency rules
(5) Executive Orders of the Governor;
(6) final decision letters from the U.S. Attorney General concerning changes in laws affecting voting in a jurisdiction subject of Section 5 of the Voting Rights Act of 1965, as required by G.S. 120-30.9H; and
(7) other information the Codifier of Rules determines to be helpful to the public.

COMPUTING TIME: In computing time in the schedule, the day of publication of the North Carolina Register is not included. The last day of the period so computed is included, unless it is a Saturday, Sunday, or State holiday, in which event the period runs until the preceding day which is not a Saturday, Sunday, or State holiday.

FILING DEADLINES

ISSUE DATE: The Register is published on the first and fifteen of each month if the first or fifteenth of the month is not a Saturday, Sunday, or State holiday for employees mandated by the State Personnel Commission. If the first or fifteenth of any month is a Saturday, Sunday, or a holiday for State employees, the North Carolina Register issue for that day will be published on the day of that month after the first or fifteenth that is not a Saturday, Sunday, or holiday for State employees.

LAST DAY FOR FILING: The last day for filing for any issue is 15 days before the issue date excluding Saturdays, Sundays, and holidays for State employees.

NOTICE OF TEXT

EARLIEST DATE FOR PUBLIC HEARING: The hearing date shall be at least 15 days after the date a notice of the hearing is published.

END OF REQUIRED COMMENT PERIOD An agency shall accept comments on the text of a proposed rule for at least 60 days after the text is published or until the date of any public hearings held on the proposed rule, whichever is longer.

DEADLINE TO SUBMIT TO THE RULES REVIEW COMMISSION: The Commission shall review a rule submitted to it on or before the twentieth of a month by the last day of the next month.

FIRST LEGISLATIVE DAY OF THE NEXT REGULAR SESSION OF THE GENERAL ASSEMBLY: This date is the first legislative day of the next regular session of the General Assembly following approval of the rule by the Rules Review Commission. See G.S. 150B-21.3, Effective date of rules.

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Notice of Application to modify existing Innovative Approval of a Wastewater System for On-site Subsurface Use

Pursuant to NCGS 130A-343(g), the North Carolina Department of Health and Human Services (DHHS) shall publish a Notice in the NC Register that a manufacturer has submitted a request for approval of a wastewater system, component, or device for on-site subsurface use. The following applications have been submitted to DHHS:

Application by: Dave Lentz
Infiltrator Water Technologies, LLC
PO Box 768
Old Saybrook, CT 06475

For: Modification of Innovative Approvals for EZflow and Chamber subsurface wastewater systems

DHHS Contact: Nancy Deal
1-919-707-5875
Fax: 919-845-3973
Nancy.Deal@dhhs.nc.gov

These applications may be reviewed by contacting the applicant or Nancy Deal, Branch Head, at 5605 Six Forks Rd., Raleigh, NC, On-Site Water Protection Branch, Environmental Health Section, Division of Public Health. Draft proposed innovative approvals and proposed final action on the application by DHHS can be viewed on the On-Site Water Protection Branch web site: http://ehs.ncpublichealth.com/oswp/.

Written public comments may be submitted to DHHS within 30 days of the date of the Notice publication in the North Carolina Register. All written comments should be submitted to Ms. Nancy Deal, Branch Head, On-site Water Protection Branch, 1642 Mail Service Center, Raleigh, NC 27699-1642, or Nancy.Deal@dhhs.nc.gov, or fax 919-845-3973. Written comments received by DHHS in accordance with this Notice will be taken into consideration before a final agency decision is made on the innovative subsurface wastewater system application.

Note from the Codifier: *The notices published in this Section of the NC Register include the text of proposed rules. The agency must accept comments on the proposed rule(s) for at least 60 days from the publication date, or until the public hearing, or a later date if specified in the notice by the agency. If the agency adopts a rule that differs substantially from a prior published notice, the agency must publish the text of the proposed different rule and accept comment on the proposed different rule for 60 days. Statutory reference: G.S. 150B-21.2.*

TITLE 13 – DEPARTMENT OF LABOR

Notice *is hereby given in accordance with G.S. 150B-21.2 that the Department of Labor intends to adopt the rule cited as 13 NCAC 07G .0101.*

Link to agency website pursuant to G.S. 150B-19.1(c): *http://www.nclabor.com*

Proposed Effective Date: *January 1, 2016*

Public Hearing:
Date: *July 16, 2015*
Time: *10:00 a.m.*
Location: *NC Department of Labor, conference room 205, 2nd Floor, 4 West Edenton St, Raleigh, NC 27601*

Reason for Proposed Action: *The North Carolina General Assembly enacted Session law 2014-76, House Bill 644 entitled: An Act Relating to the Handling of Antineoplastic Agents to Prevent an Injury Caused by Exposure. This bill established G.S. 95-156, entitled: Handling of Dangerous Antineoplastic Agents. Pursuant to that statute, the Department of Labor is required to adopt administrative rules to establish requirements for the handling of these agents.*

Comments may be submitted to: *Jane Ammons Gilchrist, NC Department of Labor, 1101 Mail Service Center, Raleigh, NC 27699, phone (919) 733-0368, email jane.gilchrist@labor.nc.gov*

Comment period ends: *August 31, 2015*

Procedure for Subjecting a Proposed Rule to Legislative Review: If an objection is not resolved prior to the adoption of the rule, a person may also submit written objections to the Rules Review Commission after the adoption of the Rule. If the Rules Review Commission receives written and signed objections after the adoption of the Rule in accordance with G.S. 150B-21.3(b2) from 10 or more persons clearly requesting review by the legislature and the Rules Review Commission approves the rule, the rule will become effective as provided in G.S. 150B-21.3(b1). The Commission will receive written objections until 5:00 p.m. on the day following the day the Commission approves the rule. The Commission will receive those objections by mail, delivery service, hand delivery, or facsimile transmission. If you have any further questions concerning the submission of objections to the Commission, please call a Commission staff attorney at 919-431-3000.

Fiscal impact (check all that apply).

- ☐ **State funds affected**
- ☐ **Environmental permitting of DOT affected**
  Analysis submitted to Board of Transportation
- ☐ **Local funds affected**
- ☐ **Substantial economic impact (≥$1,000,000)**
- ☐ **Approved by OSBM**
- ☒ **No fiscal note required by G.S. 150B-21.4**

CHAPTER 07 – OFFICE OF OCCUPATIONAL SAFETY AND HEALTH

SUBCHAPTER 07G - HANDLING OF ANTINEOPLASTIC AGENTS

SECTION .0100 - INCORPORATED STANDARDS

13 NCAC 07G .0101 HANDLING OF ANTINEOPLASTIC AGENTS

(a) The following recommendations are incorporated by reference, including subsequent amendments and editions: The recommendations issued by the National Institute for Occupational Safety and Health (NIOSH) of the Centers for Disease Control and Prevention (CDC), as contained in the Alert: Preventing Occupational Exposure to Antineoplastic and Other Hazardous Drugs in Health Care Settings, as published in 2004.

(b) Nothing in this Rule is intended to supersede existing occupational safety and health standards and regulations adopted and enforced by the North Carolina Department of Labor, including state-specific rules codified in the North Carolina Administrative Code.

Authority G.S. 95-131; 95-156.

TITLE 21 – OCCUPATIONAL LICENSING BOARDS AND COMMISSIONS

CHAPTER 16 – BOARD OF DENTAL EXAMINERS

Notice *is hereby given in accordance with G.S. 150B-21.2 that the North Carolina Board of Dental Examiners intends to adopt the rules cited as 21 NCAC 16Q .0206, .0207, .0305, .0306, .0404-.0408, .0702, .0703; amend the rules cited as 21 NCAC 16O .0301, .0302, .0401, .0402, 16Q .0101, 16Q .0201, .0202, .0204, .0301, .0302, .0304; and repeal the rules cited as 21 NCAC 16Q .0203, .0205, .0303, .0401-.0403, .0501-.0503, .0601, and .0602.*

Link to agency website pursuant to G.S. 150B-19.1(c): *www.ncdentalboard.org*

Proposed Effective Date: *November 1, 2015*

Public Hearing:
Date: *August 6, 2015*
Time: *6:30 p.m.*
Location: *Embassy Suites, 201 Harrison Oaks Boulevard, Cary, NC 27513*

Reason for Proposed Action:
21 NCAC 16O .0301 *- is proposed for amendment to clarify when a sedation permit is required to administer nitrous oxide.*
21 NCAC 16O .0302 *- is proposed for amendment to clarify the definition of monitoring nitrous oxide sedation.*
21 NCAC 16O .0401 *- is proposed for amendment to clarify who may induce nitrous oxide sedation.*
21 NCAC 16O .0402 *- is proposed for amendment to clarify when a dental assistant may help monitor nitrous oxide sedation.*
21 NCAC 16Q .0101 *- is proposed for amendment to expand and clarify the definition of terms that appear in the sedation rules.*
21 NCAC 16Q .0102 *- is proposed for amendment to increase the training requirements for general anesthesia permit holders and to clarify when a permit holder may perform general anesthesia at another dentist's office.*
21 NCAC 16Q .0202 *- is proposed for amendment to clarify what equipment must be maintained in the office of the permit holder, to clarify what information must be in the sedation record, to clarify post-operative monitoring and discharge criteria and to require two BLS certified auxiliaries to be present during all general anesthesia procedures.*
21 NCAC 16Q .0204 *- is proposed for amendment to clarify the evaluation and inspection process for applicants for general anesthesia permits.*
21 NCAC 16Q .0206 *- is proposed for adoption to create a new category of itinerant general anesthesia providers.*
21 NCAC 16Q .0207 *- is proposed for adoption to clarify the renewal process and requirements for holders of itinerant general anesthesia permits.*
21 NCAC 16Q .0301 *- is proposed for amendment to increase the training requirements for applicants for moderate conscious sedation and their auxiliaries.*
21 NCAC 16Q .0302 *- is proposed for amendment to clarify the equipment and record keeping requirements for holders of moderate conscious sedation permits, to require two BLS certified auxiliaries to be present during every procedure and to clarify post-operative monitoring and discharge criteria.*
21 NCAC 16Q .0304 *- is proposed for amendment to clarify when a moderate conscious sedation permit holder may provide sedation at another dentist's office.*
21 NCAC 16Q .0305 *- is proposed for adoption to clarify the requirements for renewal of a moderate conscious sedation permit and to increase training requirements for applicants and their auxiliaries.*
21 NCAC 16Q .0306 *- is proposed for adoption to clarify the procedure for moderate conscious sedation evaluations, inspections and re-inspections.*
21 NCAC 16Q .0404 *- is proposed for adoption to clarify the education requirements for applicants for moderate pediatric conscious sedation permits and to clarify the evaluation and inspection procedures.*
21 NCAC 16Q .0405 *- is proposed for adoption to clarify the equipment requirements for moderate pediatric conscious sedation permit holders, to require two BLS certified auxiliaries to be present during every procedure, to clarify what must be in the sedation record and to clarify post-operative monitoring and discharge criteria.*
21 NCAC 16Q .0406 *- is proposed for adoption to clarify when a moderate conscious sedation permit holder may provide sedation at another dentist's office.*
21 NCAC 16Q .0407 *- is proposed for adoption to clarify what must be done to renew a moderate conscious sedation permit and to increase the continuing education requirements for permit holders and their auxiliaries.*
21 NCAC 16Q .0408 *- is proposed for adoption to specify the evaluation, inspection and re-inspection process for moderate pediatric conscious sedation permit holders.*
21 NCAC 16Q .0702 *- is proposed for adoption to clarify when the Dental Board may inspect the facilities, equipment and records of anesthesia and sedation permit holders. It also provides that the Board will inspect all permit holders at least once every five years and will inspect permit holders with less than five years of sedation or anesthesia experience annually.*
21 NCAC 16Q .0703 *- clarifies when a sedation or anesthesia permit holder must report an adverse occurrence to the Dental Board.* ***21 NCAC 16Q .0205*** *- is proposed for repeal because the provisions of the rule have now been incorporated into another rule.*
21 NCAC 16Q .0203, .0303, .0403 *- are proposed for repeal because the Board will no longer offer temporary sedation permits.*
21 NCAC 16Q .0401, .0402 - *are proposed for repeal because the Board will no longer offer minimal conscious sedation permits.*
21 NCAC 16Q .0501, .0502 *- are proposed for repeal because the renewal requirements for general anesthesia and sedation permit holders have been incorporated into other rules.*
21 NCAC 16Q .0503 *- is proposed for repeal because the inspection requirement and procedures have been incorporated into another rule.*
21 NCAC 16Q .0601, .0602 *- are proposed for repeal because their provisions have been incorporated into other rules.*

Comments may be submitted to: *Bobby D. White, 507 Airport Blvd, Suite 150, Morrisville, NC 27560*

Comment period ends: *August 31, 2015*

Procedure for Subjecting a Proposed Rule to Legislative Review: If an objection is not resolved prior to the adoption of the rule, a person may also submit written objections to the Rules Review Commission after the adoption of the Rule. If the Rules Review Commission receives written and signed objections after the adoption of the Rule in accordance with G.S. 150B-21.3(b2) from 10 or more persons clearly requesting review by the legislature and the Rules Review Commission approves the rule, the rule will become effective as provided in G.S. 150B-21.3(b1). The Commission will receive written objections until 5:00 p.m.

on the day following the day the Commission approves the rule. The Commission will receive those objections by mail, delivery service, hand delivery, or facsimile transmission. If you have any further questions concerning the submission of objections to the Commission, please call a Commission staff attorney at 919-431-3000.

Fiscal impact (check all that apply).

☐ **State funds affected**
☐ **Environmental permitting of DOT affected**
Analysis submitted to Board of Transportation
☐ **Local funds affected**
☐ **Substantial economic impact (≥$1,000,000)**
☐ **Approved by OSBM**
☒ **No fiscal note required by G.S. 150B-21.4**

SUBCHAPTER 16O – NITROUS-OXIDE-OXYGEN CONSCIOUS SEDATION

SECTION .0300 - DEFINITIONS

21 NCAC 16O .0301 NITROUS OXIDE SEDATION

"~~Conscious~~ Nitrous oxide sedation" means the use of ~~drugs~~ nitrous oxide for controlling pain or apprehension without rendering the patient unconscious. A sedation permit is not required to administer nitrous oxide, without any other drugs, for the purpose of anxiolysis. A sedation permit is required if nitrous oxide is administered in combination with other sedative agents.

Authority G.S. 90-29(b)(6); 90-48; 90-223.

21 NCAC 16O .0302 NITROUS OXIDE MONITORING

"Monitoring" means observation of the patient during the flow of nitrous oxide ~~sedation agents~~ and includes reducing the flow of nitrous oxide ~~sedation~~ or shutting off equipment controlling such flow. Monitoring does not include starting or increasing the flow of ~~sedation agents.~~nitrous oxide.

Authority G.S. 90-29(b)(6); 90-48; 90-223.

SECTION .0400 - QUALIFICATIONS TO PERFORM FUNCTIONS

21 NCAC 16O .0401 NON-DELEGABLE FUNCTIONS

~~Conscious~~ Nitrous oxide sedation shall not be induced by anyone other than a dentist or a lawfully qualified nurse or ~~anesthetist~~ anesthesiologist who does so under the supervision and direction of a dentist or physician.

Authority G.S. 90-29(b)(6); 90-48; 90-223.

21 NCAC 16O .0402 EDUCATIONAL REQUIREMENTS

A Dental Assistant ~~I or a Dental Assistant II~~ not otherwise qualified under G.S. 90-29(c)(13) may aid and assist a licensed dentist in the ~~administration~~ monitoring of nitrous oxide-oxygen inhalant ~~conscious~~ sedation after completion of a Board-approved course totaling at least seven hours and directed by an individual or individuals approved by the Board. Such course shall include:

(1) Definitions and descriptions of physiological and psychological aspects of pain and anxiety;
(2) The states of drug-induced central nervous system depression through all levels of consciousness and unconsciousness, with special emphasis on the distinction between the conscious and unconscious state;
(3) Respiratory and circulatory physiology and related anatomy;
(4) Pharmacology of agents used in the ~~conscious~~ nitrous oxide ~~sedation~~ techniques being taught, including drug interaction and incompatibility;
(5) Patient monitoring, with particular attention to vital signs and reflexes related to consciousness;
(6) Prevention, recognition and management of complications and life threatening situations that may occur during the use of the ~~conscious sedation~~ nitrous oxide techniques, including cardio pulmonary resuscitation;
(7) Description and use of ventilation sedation equipment; and
(8) Potential health hazards of trace anesthetics, and proposed techniques for elimination of these potential health hazards.

Authority G.S. 90-29(b)(6); 90-29(c)(13); 90-48; 90-223.

SUBCHAPTER 16Q - GENERAL ANESTHESIA AND SEDATION

SECTION .0100 – DEFINITIONS

21 NCAC 16Q .0101 GENERAL ANESTHESIA AND SEDATION DEFINITIONS

For the purpose of these Rules relative to the administration of ~~minimal conscious sedation,~~ moderate conscious sedation, ~~moderate conscious sedation limited to oral routes or nitrous oxide inhalation,~~ moderate pediatric conscious sedation or general anesthesia by or under the direction of a dentist, the following definitions shall apply:

(1) "Analgesia" – the diminution or elimination of pain.
(2) "Anti-anxiety sedative" – a sedative agent administered in a dosage intended to reduce anxiety without diminishing consciousness or protective reflexes.
(3) "Anxiolysis" – pharmacological reduction of anxiety through the administration of a single dose of ~~a~~ any ~~minor~~ anti-anxiety drug ~~psychosedative,~~ within a 24 hour period, or nitrous oxide ~~possibly in combination with nitrous oxide,~~ to children or adults prior to commencement of treatment on the day of the appointment which allows for uninterrupted interactive ability in a totally awake patient

with no compromise in the ability to maintain a patent airway continuously and without assistance. ~~Nitrous oxide may be administered in addition to the minor psychosedative without constituting multiple dosing for purpose of these Rules.~~ The patient must be able to respond normally to tactile stimulation and verbal commands and walk normally. A dentist may perform anxiolysis without obtaining a permit from the Dental Board.

(4) "ACLS" – Advanced cardiac life support.

(5) "Administer"—to direct, manage, supervise, control and have charge of all aspects of selection, dosage, timing and method of delivery to the patient of any pharmacologic agent intended to reduce anxiety or depress consciousness.

~~(17)~~(6) "Anti-Anxiety Drug ~~Minor psychosedative/Minor tranquilizer"~~ - pharmacological agents which allow for uninterrupted interactive ability in a patient with no compromise in the ability to maintain a patent airway continuously and without assistance and carry a margin of safety wide enough to render unintended loss of consciousness unlikely. The patient must be able to respond normally to tactile stimulation and verbal commands and walk normally.

(7) "ASA" – American Society of Anesthesiologists.

(8) "Auxiliaries" – non-dentist staff members directly involved in general anesthesia or sedation procedures.

(9) "BLS" – Basic life support.

~~(4)~~(10) "Behavior control" – the use of pharmacological techniques to control behavior to a level at which~~that~~ dental treatment can be performed effectively and efficiently.

~~(5)~~(11) "Behavioral management" – the use of pharmacological or psychological techniques, singly or in combination, to modify behavior to a level that dental treatment can be performed effectively and efficiently.

~~(6)~~(12) "Competent" – displaying special skill or knowledge derived from training and experience.

~~(7)~~(13) "Conscious sedation" - an induced state of a depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation and verbal command, and that is produced by pharmacologic or non-pharmacologic agents, or a combination thereof. In accordance with this particular definition, the drugs or techniques used shall carry a margin of safety wide enough to render unintended loss of consciousness unlikely. All dentists who perform conscious sedation shall have a current sedation permit from the Dental Board.

(14) "CRNA" – certified registered nurse anesthetist.

~~(8)~~(15) "Deep sedation" – an induced state of a depressed level of consciousness accompanied by partial loss of protective reflexes, including the ability to continually maintain an airway independently or respond purposefully to verbal command, ~~and is~~ produced by pharmacological agents. All dentists who perform deep sedation shall have a current general anesthesia permit from the Dental Board.

(16) "Deliver" – to assist a properly qualified dentist in administering sedation or anesthesia drugs by providing the drugs directly to the patient pursuant to a direct order from the dentist and while under the dentist's direct supervision.

~~(9)~~(17) "Direct supervision" – the dentist responsible for the ~~sedation/anesthesia~~ sedation or anesthesia procedure shall be physically present in the facility and shall be continuously aware of the patient's physical status and well being.

(18) "Emergencies manual" – a written or digital manual that documents 1) the location of all emergency equipment and medications in each dental office, 2) each staff member's role during medical emergencies and 3) the appropriate treatment for laryngospasm, bronchospasm, emesis and aspiration, respiratory depression and arrest, angina pectoris, myocardial infarction, hypertension, hypotension, allergic reactions, convulsions, syncope, bradycardia, insulin shock, cardiac arrest and airway obstruction.

(19) "ET CO2" - end tidal carbon dioxide.

~~(10)~~(20) "Facility" – the location where a permit holder practices dentistry and provides ~~anesthesia/sedation~~ anesthesia or sedation services.

~~(11)~~(21) "Facility inspection" - an on-site inspection to determine if a facility where the applicant proposes to provide ~~anesthesia/sedation~~anesthesia or sedation is supplied, equipped, staffed and maintained in a condition to support provision of ~~anesthesia/sedation~~ anesthesia or sedation services that meet the minimum standard of care.

~~(12)~~(22) "General anesthesia" - the intended controlled state of a depressed level of consciousness that is produced by pharmacologic agents and accompanied by a partial or complete loss of protective reflexes, including the ability to maintain an airway and respond purposefully to physical stimulation or verbal commands.

(23) "Good standing" – a licensee whose license is not suspended or revoked and who is not subject to a current disciplinary order imposing probationary terms.

~~(13)~~(24) "Immediately available" – on-site in the facility and available for immediate use.

(25) Itinerant general dentist anesthesiologist – a licensee who has complied with Rule .0206 of this Subchapter and who administers general anesthesia at another practitioner's facility.

~~(14)~~(26) "Local anesthesia" – the elimination of sensations, especially pain, in one part of the body by the regional application or injection of a drug.

~~(15)~~(27) "May" – indicates freedom or liberty to follow a reasonable alternative.

~~(16) "Minimal conscious sedation" – conscious sedation characterized by a minimally depressed level of consciousness, in which patient retains the ability to independently and continuously maintain an airway and respond normally to tactile stimulation and verbal command, provided to patients 13 years or older, by oral or rectal routes of administration of a single pharmacological agent, in one or more doses, not to exceed the manufacturer's maximum recommended dose, at the time of treatment, possibly in combination with nitrous oxide. Minimal conscious sedation is provided for behavioral management.~~

~~(18)~~(28) "Moderate conscious sedation" – conscious sedation characterized by a drug induced depression of consciousness, during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation, provided to patients 13 years or older, by oral, nasal, rectal or parenteral routes of administration of multiple pharmacological agents, in multiple doses, within a 24 hour period, including the time of treatment, possibly in combination with nitrous oxide. Moderate conscious sedation is provided for behavior control.

~~(19) "Moderate conscious sedation limited to oral routes and nitrous oxide inhalation" – conscious sedation characterized by a drug induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation, provided to patients 13 years or older, by oral routes of administration and nitrous oxide inhalation, of single or multiple pharmacological agents, in single or multiple doses, within a 24 hour period. Moderate conscious sedation limited to oral routes and nitrous oxide inhalation is provided for behavior control.~~

(29)~~(20)~~ "Moderate pediatric conscious sedation" - conscious sedation characterized by a drug induced depression of consciousness, during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation, provided to patients up to ~~under~~ 18 ~~13~~ years of age, or special needs patients, by oral, nasal, rectal or parenteral routes of administration of single or multiple pharmacological agents, in single or multiple doses, within a 24 hour period, including the time of treatment, possibly in combination with nitrous oxide. Moderate pediatric conscious sedation is provided for behavior control.

(30)~~(21)~~ "Must" or "shall" – indicates an imperative need or duty or both; an essential or indispensable item; mandatory.

(31)~~(22)~~ "Parenteral" - the administration of pharmacological agents intravenously, intraosseously, intramuscularly, subcutaneously, submucosally, intranasally, or transdermally.

(32) "PALS" – Pediatric Advanced Life Support.

(33)~~(23)~~ "Protective reflexes" – includes the ability to swallow and cough.

(34) Special needs patients – patients with diminished mental and or physical capacity who are unable to cooperate sufficiently to receive ambulatory dental care without sedation or anesthesia.

(35)~~(24)~~ "Supplemental dosing" – the oral administration of a pharmacological agent that results in an enhanced level of conscious sedation when added to the primary sedative agent administered for the purpose of oral moderate conscious sedation, and which, when added to the primary agent, does not exceed the maximum safe dose of either agent, separately or synergistically.

(36)~~(25)~~ "Vested adult" – a responsible adult who is the legal parent or guardian, or designee of a legal parent or guardian, entrusted with the care of a ~~minor~~ patient following the administration of general anesthesia or conscious sedation.

Authority G.S. 90-28; 90-30.1.

SECTION .0200 - GENERAL ANESTHESIA

21 NCAC 16Q .0201 GENERAL ANESTHESIA CREDENTIALS AND PERMIT

~~(a) No dentist shall employ or use general anesthesia on an outpatient basis for dental patients unless the dentist possesses a permit issued by the Board. A dentist holding a permit shall be subject to review and shall only employ or use general anesthesia at a facility located in the State of North Carolina in accordance with 21 NCAC 16Q .0202. Such permit must be renewed~~

~~annually and shall be displayed with the current renewal at all times in a conspicuous place in the office of the permit holder.~~

(a) Before a dentist licensed to practice in North Carolina may administer or supervise a CRNA or RN to administer general anesthesia, the dentist shall obtain a general anesthesia permit from the Board by completing an application form and paying a four hundred seventy five dollar ($475.00) fee. The application form is available on the Board's website: www.ncdentalboard.org. The permit shall be renewed annually and shall be displayed with the current renewal at all times in the permit holder's facility where it is visible to patients receiving treatment.

(b) A dentist applying for a general anesthesia permit shall be in good standing with the Board and demonstrate that he or she:

~~(b) Any dentist who wishes to administer general anesthesia to patients must apply to the Board for the required permit on a prescribed application form, submit an application fee of one hundred dollars ($100.00) and produce evidence showing that he or she:~~

(1) Has completed a minimum of two years ~~one year~~ of advanced training in anesthesiology and related academic subjects ~~(or its equivalent)~~ beyond the undergraduate dental school level; or

(2) Has graduated from a program certified by the American Dental Association in Oral and Maxillofacial Surgery; or

(3) Is a Diplomate of or eligible for examination by the American Board of Oral and Maxillofacial Surgery; or

(4) Is a Fellow of the American Dental Society of Anesthesiology; ~~or~~ and

~~(5) Is a dentist who has been administering general anesthetics in a competent manner for the five years preceding the effective date of this Rule.~~

(5) Has current ACLS certification.

(c) Before receiving a general anesthesia permit, all applicants shall pass an evaluation and inspection as set out in Rule .0202 of this Section. Every location other than a hospital or credentialed surgery center where a general anesthesia permit holder administers general anesthesia shall pass an inspection as set out in Rule .0202 of this Section.

~~(c)~~(d) A dentist who ~~is qualified to administer general anesthesia in accordance with this Section and~~ holds a general anesthesia permit may ~~is also authorized to~~ administer any level of sedation without obtaining a separate sedation permit.

~~(d) The dentist involved with the administration of general anesthesia s~~hall document current, successful completion of ~~advanced cardiac life support (ACLS) training, or its age specific equivalent or other Board approved equivalent course and auxiliary personnel shall document annual, successful completion of basic life support (BLS) training.~~

(e) A dentist who does not hold a general anesthesia permit may not employ a CRNA or RN to provide general anesthesia services. A dentist who holds a general anesthesia permit may permit a CRNA to provide general anesthesia services under direct supervision of the dentist.

(f) A general anesthesia permit holder may provide general anesthesia or any level of sedation at the office of another licensed dentist, regardless of the permit, if any held, by the hosting dentist. The permit holder shall ensure that the facility where the general anesthesia or sedation is administered has been inspected and complies with the requirements set out in Rule .0202 of this Section or shall obtain an itinerant general anesthesia permit and comply with the provisions of Rule .0206 of this Section.

Authority G.S. 90-28; 90-30.1.

21 NCAC 16Q .0202 GENERAL ANESTHESIA EQUIPMENT AND CLINICAL REQUIREMENTS

(a) A dentist administering general anesthesia shall ensure ~~is solely responsible for providing~~ that the facility ~~environment in which~~ where the general anesthesia is ~~to be~~ administered meets the following requirements:

(1) The facility is equipped with:

(A) An operatory of size and design to permit access of emergency equipment and personnel and to permit effective emergency management;

(B) ~~A chair or table for emergency treatment, including chair suitable for CPR or CPR Board;~~ A CPR board or dental chair without enhancements suitable for providing emergency treatment;

(C) Lighting as necessary for specific procedures ~~procedures; and~~ back-up lighting; and

(D) Suction equipment as necessary for specific procedures; including non-electrical back-up ~~suction;~~ suction.

(2) The following equipment is maintained:

(A) Positive pressure oxygen delivery system, including full face masks for adults and pediatric patients ~~patients;~~ and back-up E-cylinder portable oxygen tank apart from the central system;

(B) Small, medium and large oral ~~Oral~~ and nasal airways; ~~airways of various sizes;~~

(C) Blood pressure monitoring device;

(D) EKG Monitor; ~~Electrocardiograph~~;

(E) Pulse oximeter; ~~and~~

(F) Defibrillator;

(G) Capnograph;

(H) Thermometer;

~~(3) The following emergency equipment is maintained:~~

~~(A)~~(I) ~~I.V. set up~~ Vascular access as necessary for specific procedures, including hardware and fluids;

~~(B)~~(J) Laryngoscope with current batteries;

~~(C)~~(K) Intubation forceps and ~~endotracheal tubes;~~ advanced airway devices;

~~(D)~~(L) Tonsillar suction with back-up suction;
~~(E)~~(M) Syringes as necessary for specific procedures; and
~~(F)~~(N) Tourniquet ~~& tape; and~~ and tape.
~~(G) Blood pressure monitoring device;~~

~~(4)~~(3) The following drugs are maintained with a current shelf life and with access from the operatory and recovery room:
(A) Epinephrine;
(B) Atropine;
(C) ~~Lidocaine;~~ Antiarrhythmic;
(D) Antihistamine;
(E) Antihypertensive;
(F) ~~Bronchial dilator;~~ Bronchodilator;
(G) Antihypoglycemic agent;
(H) Vasopressor;
(I) Corticosteroid;
(J) Anticonvulsant;
(K) Muscle relaxant;
(L) Appropriate reversal agents;
~~(M) Appropriate anti arrhythmic medication;~~
(M)~~(N)~~ Nitroglycerine; and
(N)~~(O)~~ ~~Antiemetic;~~ Antiemetic.

~~(5)~~(4) Written emergency and patient discharge protocols and training to familiarize ~~office personnel~~ auxiliaries in the treatment of clinical emergencies are provided; and

~~(6)~~(5) The following records are ~~maintained:~~ maintained for 10 years:
(A) Patient's current written medical history, including a record of known allergies and previous surgeries; ~~surgery;~~
(B) Signed consent to general anesthesia form identifying the risks and benefits, level of anesthesia and date signed;
(C) Signed consent identifying the procedure, risks and benefits and date signed;
(D)~~(B)~~ Base line vital signs, including temperature, SPO2, blood pressure and pulse;
(E)~~(C)~~ An anesthesia record;~~record which shall include:~~
~~(i) Periodic vital signs taken at intervals during the procedure;~~
~~(ii) Drugs administered during the procedure, including route of administration, dosage, time and sequence of administration~~;
~~(iii) Duration of the procedure;~~
~~(iv) Documentation of complications or morbidity; and~~
~~(v) Status of patient upon discharge.~~
(6) The sedation record shall include:
(A) base line vital signs, blood pressure (unless patient behavior prevents recording); oxygen saturation, ET CO2, pulse and respiration rates recorded in real time at 15 minute intervals;
(B) procedure start and end times;
(C) gauge of needle and location of IV, if used;
(D) status of patient upon discharge;
(E) documentation of complications or morbidity.

~~(d)~~(7) ~~A dentist administering general anesthesia shall ensure that the~~ The facility shall be ~~is~~ staffed with at least two BLS certified ~~auxiliary personnel~~ auxiliaries who shall be present at all times during the procedure and at least one of whom shall be dedicated to patient monitoring and recording general anesthesia or sedation data. ~~document annual successful completion of basic life support training and be capable of assisting with procedures, problems, and emergency incidents that may occur as a result of the general anesthetic or secondary to an unexpected medical complication.~~

(b) During an inspection or evaluation, the applicant or permit holder shall demonstrate the administration of anesthesia while the evaluator ~~observes. During the demonstration, the applicant or permit holder~~ observes, and shall demonstrate competency in the following areas:
(1) Monitoring of blood pressure, pulse, ET CO2, and respiration;
(2) Drug dosage and administration;
(3) Treatment of untoward reactions including respiratory or cardiac depression;
(4) Sterilization;
(5) Use of BLS ~~CPR~~ certified auxiliaries; ~~personnel;~~
(6) Monitoring of patient during recovery; and
(7) Sufficiency of patient recovery time.

(c) During an inspection or evaluation, the applicant or permit holder shall verbally demonstrate competency ~~to the evaluator~~ in the treatment of the following clinical emergencies:
(1) Laryngospasm;
(2) Bronchospasm;
(3) Emesis and aspiration;
(4) Respiratory depression and arrest;
(5) Angina pectoris;
(6) Myocardial infarction;
(7) ~~Hypertension/Hypotension;~~ Hypertension and Hypotension;
(8) Syncope;
(9) Allergic reactions;
(10) Convulsions;
(11) Bradycardia;
(12) Insulin shock; ~~and~~
(13) Cardiac arrest; and

(14) Airway obstruction.

(d) A general anesthesia permit holder shall evaluate patients for health risks before starting any anesthesia procedure.

(e) Post-operative monitoring and discharge:

(1) Vital signs shall be continuously monitored when the sedation is no longer being administered and the patient shall have direct continuous supervision until oxygenation and circulation are stable and the patient is sufficiently responsive for discharge from the office.

(2) Recovery from general anesthesia shall include documentation of the following:

(A) cardiovascular function stable;

(B) airway patency uncompromised;

(C) patient easily arousable and protective reflexes intact;

(D) state of hydration within normal limits;

(E) patient can talk, if applicable;

(F) patient can sit unaided, if applicable;

(G) patient can ambulate, if applicable, with minimal assistance; and

(H) for the patient who is disabled, or incapable of the usually expected responses, the pre-sedation level of responsiveness or the level as close as possible for that patient shall be achieved.

(3) Before allowing the patient to leave the office, the dentist shall determine that the patient has met the recovery criteria set out in Subparagraph (e)(2) of this Rule and the following discharge criteria:

(A) oxygenation, circulation, activity, skin color and level of consciousness are sufficient and stable and have been documented;

(B) explanation and documentation of written postoperative instructions have been provided to the patient or a responsible adult at time of discharge; and

(C) responsible individual is available for the patient to transport the patient after discharge.

Authority G.S. 90-28; 90-30.1; 90-48.

21 NCAC 16Q .0203 TEMPORARY APPROVAL PRIOR TO SITE EVALUATION

~~(a) If a dentist meets the requirements of Rule .0201 of this Section, he shall be granted temporary approval to continue to administer general anesthesia until a permit can be issued. Temporary approval may be granted based solely on credentials until all processing and investigation has been completed. Temporary approval may not exceed three months. An on site evaluation of the facilities, equipment, procedures, records and personnel shall be required prior to the issuance of a permit.~~

~~(b) An evaluation may be made any time it is deemed necessary by the Board.~~

~~(c) Temporary approval shall not be granted to a provisional licensee.~~

Authority G.S. 90-28; 90-30.1.

21 NCAC 16Q .0204 PROCEDURE FOR GENERAL ANESTHESIA EVALUATION OR INSPECTION AND RE-INSPECTION

(a) When an evaluation or on-site inspection is required, the Board will designate two or more qualified persons, each of ~~which~~ whom has administered general anesthesia for at least three years preceding the inspection, exclusive of his or her training in general anesthesia. When an on-site inspection involves only a facility and equipment check and not an evaluation of the dentist, the inspection may be accomplished by one or more evaluators.

(b)~~(e) At least a 15 day notice shall be given prior to an evaluation or inspection. The entire evaluation fee of three hundred seventy five dollars ($375.00) shall be due 10 days after the date of receipt of such notice.~~ An inspection fee of ~~two hundred seventy five dollars ($275.00)~~ three hundred seventy five dollars ($375.00) shall be due 10 days after the dentist receives notice of the inspection of each additional location at which the dentist administers general anesthesia.

~~(b)~~(c) Any dentist-member of the Board may observe or consult in any evaluation.

~~(c)~~(d) The inspection team shall determine compliance with the requirements of the Rules in this Subchapter, as applicable, by assigning a grade of "pass" or "fail".

~~(d)~~(e) Each evaluator shall report his or her recommendation to the ~~Board,~~ Board's Anesthesia and Sedation Committee, setting forth the details supporting his or her conclusion. The ~~Board~~ Committee is not bound by these recommendations. The ~~Board~~ Committee shall determine whether the applicant has passed the ~~evaluation/inspection~~ evaluation or inspection and shall notify the applicant in writing of its decision.

(f) An applicant who fails an inspection or evaluation shall not receive a permit to administer general anesthesia. If a permit holder fails an evaluation, the permit shall be summarily suspended. If a permit holder's facility fails an inspection, no further anesthesia procedures may be performed at the facility until it passes a re-inspection by the Board.

(g) An applicant who fails an inspection or evaluation may request a re-evaluation or re-inspection within 15 days of receiving the notice of failure. The request shall include a statement of the grounds supporting the re-evaluation or re-inspection. The Board shall require the applicant to receive additional training prior to the re-evaluation to address the areas of deficiency determined by the evaluation.

(h) Re-evaluations and re-inspections shall be conducted by Board-appointed evaluators not involved in the failed evaluation or inspection.

Authority G.S. 90-28; 90-30.1; 90-39.

21 NCAC 16Q .0205 RESULTS OF SITE EVALUATION AND REEVALUATION

~~(a) An applicant who fails an inspection or evaluation shall not receive a permit to administer general anesthesia, or if the holder of a permit, shall not have it renewed. An applicant who has obtained temporary approval from the Board and fails an inspection or evaluation shall no longer be approved.~~

~~(b) An applicant who receives notification of failure of an inspection may, within 15 days after receiving the notice, request a reevaluation. Such request must state specific grounds supporting it. The Board shall require the applicant to receive additional training prior to the reevaluation. The additional training shall consist of, but not be limited to, areas of deficiency as determined by the evaluation.~~

~~(c) If the reevaluation is granted, it shall be conducted by different persons, qualified as evaluators, in the manner prescribed in Rule .0204 of this Section.~~

~~(d) No applicant who has received a failing notice from the Board may request more than one reevaluation within any 12 month period.~~

Authority G.S. 90-28; 90-30.1.

21 NCAC 16Q .0206 ITINERANT (MOBILE) GENERAL ANESTHESIA PERMIT, EQUIPMENT AND EVALUATION

(a) A dentist who holds a general anesthesia permit from the Board and who wishes to provide general anesthesia or other sedation services in the office of another practitioner shall obtain a mobile general anesthesia permit from the Board. The application form may be obtained on the Board's website: www.ncdentalboard.org and shall be accompanied by a one hundred dollar ($100.00) fee. No mobile permit is required to administer general anesthesia in a hospital or credentialed surgery center.

(b) Before a mobile general anesthesia permit is issued, a general anesthesia permit holder appointed by the Board shall inspect the applicant's equipment and medications to ensure that they comply with Paragraphs (c) and (d) of this Rule.

(c) The following equipment shall be maintained:

(1) Positive pressure ventilation system and back-up E cylinder portable oxygen tank;
(2) Standard ASA monitors with back-up power;
(3) EKG Monitor;
(4) Capnograph;
(5) Small, medium and large oral airways and nasal trumpets;
(6) Small, medium and large laryngoscope blades and back-up laryngoscope;
(7) Small, medium and large nasal and oral endotracheal tubes;
(8) Magill forceps;
(9) Small, medium and large supraglottic airway devices;
(10) Back-up suction;
(11) Defibrillator with pediatric capability;
(12) Small, medium and large anesthesia circuits;
(13) Back-up lighting;
(14) Gastric suction device;
(15) Endotracheal tube and pulmonary suction device;
(16) Equipment for performing emergency cricothyrotomies and delivering positive pressure ventilation;
(17) Back-up ventilation measurement;
(18) Rebreathing device;
(19) Scavenging system;
(20) Intermittent compression devices;
(21) CPR board or dental chair suitable for providing emergency treatment;
(22) Laryngoscope with current batteries; and
(23) Tourniquet and tape.

(d) The following current medications shall be immediately accessible:

(1) Epinephrine;
(2) Atropine;
(3) Antiarrhythmic
(4) Antihistamine;
(5) Antihypertensive;
(6) Bronchodilator;
(7) Antihypoglycemic agent;
(8) Vasopressor;
(9) Corticosteroid;
(10) Anticonvulsant;
(11) Muscle relaxant;
(12) Appropriate reversal agents;
(13) Nitroglycerine;
(14) Antiemetic;
(15) Neuromuscular blocking agent; and
(16) Anti-malignant hyperthermia agent.

(e) The evaluation and inspection shall be conducted as set out in Rule .0204 of this Section.

(f) Before administering general anesthesia or sedation at another provider's office, the mobile permit holder shall inspect the host facility to ensure that:

(1) The operatory is of sufficient size and design to permit effective emergency management and access of emergency equipment and personnel;
(2) There is a CPR board or dental chair without enhancements suitable for providing emergency treatment;
(3) There is sufficient lighting;
(4) There is suction equipment, including non-electrical back-up suction; and
(5) At least two BLS certified auxiliaries shall be present during all procedures.

(g) At least 24 hours before the procedure is scheduled to begin, the mobile permit holder shall send written notice to the Board office confirming that the facility where the general anesthesia or sedation will be performed meets the requirements of Paragraph (f) of this Rule and documenting when the inspection was conducted. The permit holder shall retain a copy of the written notice for 10 years following the procedure. No procedure may be performed if the report is not filed as required by this Paragraph.

(h) The mobile general anesthesia permit shall be displayed in the host facility where it is visible to patients receiving treatment.
(i) All applicants for mobile general anesthesia permit shall be in good standing with the Board.

Authority G.S. 90-28; 90-30.1; 90-48.

21 NCAC 16Q .0207 ANNUAL RENEWAL OF GENERAL ANESTHESIA AND ITINERANT (MOBILE) GENERAL ANESTHESIA PERMIT REQUIRED

(a) General anesthesia permits shall be renewed by the Board annually at the same time as dental licenses by paying a one hundred dollar ($100.00) fee and completing an application available from the Board's website: www.ncdentalboard.org. If the completed renewal application and renewal fee are not received before January 31 of each year, a one hundred dollar ($100.00) late fee shall be paid.
(b) Itinerant general anesthesia permits shall be renewed by the Board annually at the same time as dental licenses by paying a one hundred dollar ($100.00) fee and completing an application available from the Board's website: www.ncdentalboard.org. If the completed itinerant general sedation permit and renewal fee are not received before January 31 of each year, a one hundred dollar ($100.00) late fee shall be paid.
(c) Any dentist who fails to renew a general anesthesia permit or itinerant general anesthesia permit before March 31 of each year shall complete a reinstatement application, pay the renewal fee and late fee and comply with all conditions for renewal set out in this Rule. Dentists whose anesthesia permits or itinerant general anesthesia permits have been lapsed for more than 12 calendar months shall pass an inspection and an evaluation as part of the reinstatement process.
(d) A dentist who continues to administer general anesthesia or any level of sedation in violation of this Rule shall be subject to the penalties prescribed by Rule .0701 of this Subchapter.
(e) As a condition for renewal of the general anesthesia and itinerant general anesthesia permit the permit holder shall maintain the clinical equipment and requirements set out in Rules .0202 and .0206 of this Section and document:

(1) six hours of continuing education each year in one or more of the following areas, which may be counted toward fulfillment of the continuing education required each calendar year for license renewal:
  (A) sedation;
  (B) medical emergencies;
  (C) monitoring IV sedation and the use of monitoring equipment;
  (D) pharmacology of drugs and agents used in general anesthesia and IV sedation;
  (E) physical evaluation, risk assessment, or behavioral management; or
  (F) airway management; and
(2) current ACLS, which shall not count towards the six hours required in Paragraph (e); and
(3) that the permit holder and all auxiliaries have practiced responding to dental emergencies as a team at least once every six months in the preceding year; and
(4) that the permit holder and all auxiliaries have read the practice's emergency manual in the preceding year; and
(5) that all permit holder auxiliaries have completed BLS and six hours of continuing education in medical emergencies annually.

Authority G.S. 90-28; 90-30.1; 90-48.

SECTION .0300 MODERATE CONSCIOUS SEDATION

21 NCAC 16Q .0301 CREDENTIALS AND PERMITS FOR MODERATE CONSCIOUS SEDATION

(a) Before a dentist licensed to practice in North Carolina may administer or supervise a ~~certified registered nurse anesthetist (CRNA)~~ CRNA or RN to administer moderate conscious sedation, ~~moderate pediatric conscious sedation or moderate conscious sedation limited to oral routes of administration and nitrous oxide to dental patients on an outpatient basis~~, the dentist shall obtain a permit from the Board by completing an application form ~~provided by the Board~~ and paying a fee of ~~one hundred dollars ($100.00).~~three hundred seventy five dollars ($375.00). The application form is available on the Board's website: www.ncdentalboard.org. The ~~Such~~ permit shall be renewed annually and shall be displayed with the current renewal at all times ~~in a conspicuous place~~ in the facility of the permit ~~holder.~~ holder where it is visible to patients receiving treatment.
(b) The permit holder shall directly supervise any CRNA or RN employed to administer sedation and shall ensure that the level and duration of the sedation does not exceed the permit holder's permit.
~~(b) For a dentist to employ a certified registered nurse anesthetist to administer moderate conscious sedation, moderate conscious sedation limited to oral routes and nitrous oxide or moderate pediatric conscious sedation, the dentist must demonstrate through the permitting process that he or she is capable of performing all duties and procedures to be delegated to the CRNA The dentist must not delegate said CRNA perform procedures outside of the scope of the technique and purpose of moderate conscious sedation, moderate pediatric conscious sedation or moderate conscious sedation limited to oral routes and nitrous oxide as defined in Rule .0101 of this Subchapter.~~
(c) A dentist applying for a permit to administer moderate conscious sedation ~~or moderate pediatric conscious sedation~~ shall ~~must meet at least one of the following criteria:~~ document:

(1) ~~Satisfactory completion~~ Completion of a minimum of 90 ~~60~~ hours of Board approved didactic training, ~~including PALS (Pediatric Advanced Life Support), and~~ instruction in intravenous conscious sedation and satisfactory management of a minimum of ~~10~~ 20 live patients, under supervision, using intravenous sedation; or
(2) ~~Satisfactory completion~~ Completion of a pre-doctoral dental or postgraduate program which included intravenous conscious sedation

training equivalent to that defined in Subparagraph (c)(1) of this Rule; ~~or~~ and

(3) Current ACLS; and

(4) That all auxiliaries have current BLS certification.

~~(3) Satisfactory completion of a pre-doctoral dental or postgraduate program which included intravenous conscious sedation training equivalent to that defined in Subparagraph (c)(1) of this Rule.~~

~~(d) Notwithstanding the foregoing, a dentist may also qualify for a permit to administer moderate pediatric conscious sedation by documenting, with patient names and dates of completion, at least 100 cases of moderate pediatric sedation procedures successfully completed between July 3, 2006 and July 3, 2009. A dentist who obtains a pediatric conscious sedation permit pursuant to this Paragraph may not administer sedation intravenously and such limitation shall be noted on the dentist's permit.~~

~~(e) A dentist may modify his or her moderate conscious sedation permit to include the privilege of moderate pediatric conscious sedation by completing a Board approved pediatric dental degree or pediatric dental residency program or obtaining the equivalent hours of continuing education program in pediatric dental anesthesia. If said qualifications are satisfied, it shall be so designated on the dentist's moderate conscious sedation permit and will be subject to the renewal requirements stated in Rule .0501(d) of this Subchapter.~~

~~(f) To be eligible for a moderate conscious sedation permit, moderate conscious sedation limited to oral routes and nitrous oxide inhalation permit or moderate pediatric conscious sedation permit, a dentist must operate within a facility which includes the capability of delivering positive pressure oxygen, and is staffed with supervised auxiliary personnel for each procedure performed. The dentist shall ensure that auxiliary personnel document annual, successful completion of basic life support (BLS) training and are capable of assisting with procedures, problems and emergencies incident thereto.~~

(d) All applicants for a moderate conscious sedation permit shall be in good standing with the Board.

(e)~~(g)~~ Prior to issuance of a moderate conscious sedation permit, ~~moderate conscious pediatric sedation permit or moderate conscious sedation permit limited to oral routes and nitrous oxide inhalation permit,~~ the applicant shall ~~undergo~~ pass an evaluation ~~which includes~~ and a facility inspection. The Board shall direct an evaluator to perform this evaluation. ~~The applicant shall be notified in writing that an evaluation and facility inspection is required and provided with the name of the evaluator who shall perform the evaluation and facility inspection.~~ The applicant shall be responsible for successful completion of the evaluation and inspection of his or her facility within ~~three months~~ 90 days of notification. An extension of no more than 90 days shall be granted if the designated evaluator or applicant requests one.

(f) The entire fee of three hundred seventy five dollars ($375.00) shall be due 10 days after the applicant receives notice of the inspection of each additional location at which the dentist administers sedation.

~~(h)~~(g) The evaluator shall assign a grade of pass or fail and shall report his or her recommendation to the Board, setting out the basis for his or her conclusion. The ~~Board,~~ Board's Anesthesia and Sedation Committee is not bound by the evaluator's recommendation and shall make a final determination regarding whether the applicant has passed the evaluation. The applicant shall be notified of the Committee's ~~Board's~~ decision in writing.

(h) An applicant who fails an inspection or an evaluation shall not receive a sedation permit.

(i) An applicant who fails an inspection or evaluation may request a re-evaluation or re-inspection within 15 days of receiving the notice of failure. The request shall state specific grounds supporting it. The Board shall require the applicant to receive additional training prior to the re-evaluation to address the areas of deficiency determined by the evaluation.

(j) Re-inspections and re-evaluations shall be conducted by evaluators not involved in the failed inspection or evaluation.

(k) An applicant who does not pass the evaluation and inspection within the time allowed by Paragraph (e) of this Rule shall reapply and pay an additional three hundred seventy five dollar ($375.00) fee.

~~(i)~~(l) A dentist who holds a moderate conscious sedation, ~~moderate conscious sedation limited to oral routes and nitrous oxide inhalation or moderate pediatric conscious sedation~~ permit shall not intentionally administer deep ~~sedation~~ sedation. ~~although deep sedation may occur briefly and unintentionally~~.

~~(j) A dentist may obtain a moderate conscious sedation permit limited to oral routes of administration and nitrous oxide inhalation, including the ability to add supplemental dosing to the techniques set out in Rule .0101(23) of this Subchapter upon compliance with the following requirements:~~

~~(1) successfully complete 24 hours of didactic training and manage at least 10 adult case experiences, including at least three live clinical dental experiences. The live clinical cases shall not be handled by groups with more than five student participants. The remaining cases may include simulations, video presentations or both, but must include one experience in returning/rescuing a patient from deep to moderate sedation; or~~

~~(2) document, with patient names and dates of completion, at least 100 cases of oral moderate conscious sedation procedures successfully completed within one year preceding June 3, 2008; and fulfill all the requirements listed in Rule .0401 of this Subchapter for minimal conscious sedation.~~

~~(k) A dentist who is qualified to administer general anesthesia, moderate conscious sedation or moderate pediatric conscious sedation and holds a general anesthesia, moderate conscious sedation permit or a moderate pediatric conscious sedation permit may administer minimal conscious sedation or moderate conscious sedation limited to oral routes without obtaining an additional a separate minimal conscious sedation permit.~~

~~(l) Any dentist who holds an active parenteral conscious sedation permit as of October 1, 2007 shall be deemed to hold an active moderate conscious sedation permit. Such permits shall be subject to the renewal requirements set out in Rule .0501 of this Subchapter.~~

Authority G.S. 90-28; 90-30.1.

21 NCAC 16Q .0302 MODERATE CONSCIOUS SEDATION CLINICAL REQUIREMENTS AND EQUIPMENT

(a) A dentist administering moderate conscious sedation ~~or moderate pediatric conscious sedation~~ or supervising the administration of moderate conscious sedation ~~or moderate pediatric conscious sedation by a certified registered nurse anesthetist~~ by a CRNA or RN shall ensure that the facility in which the sedation is ~~to be~~ administered meets the following requirements:

(1) The facility is equipped with:
- (A) An operatory of size and design to permit access of emergency equipment and personnel and to permit effective emergency management;
- (B) A CPR ~~Board~~ board or a dental chair without enhancements, suitable for providing emergency treatment;
- (C) Lighting as necessary for specific ~~procedures;~~ procedures and back-up lighting; and
- (D) Suction equipment as necessary for specific procedures, including non-electrical back-up suction.

(2) The following equipment is maintained:
- (A) Positive oxygen delivery system, including full face masks for ~~adults and pediatric~~ small, medium and large patients and back-up E-cylinder portable oxygen tank apart from the central system;
- (B) Small, medium and large ~~Oral~~ oral and nasal airways; ~~airways of various sizes;~~
- (C) Blood pressure monitoring device;
- (D) Pulse oximeter; ~~and~~
- (E) ~~Automatic External~~ Defibrillator ~~(AED).~~
- (F) EKG Monitor;
- (G) Capnograph; and
- (H) Thermometer.

~~(3) The following emergency equipment is maintained:~~
- ~~(A)~~(I) ~~I.V.~~ Vascular access set-up as necessary for specific procedures, including hardware and fluids; ~~fluids, if anesthesia is intravenous~~;
- ~~(B)~~(J) Syringes as necessary for specific procedures; ~~and~~
- ~~(C)~~(K) Tourniquet and ~~tape~~ tape;
- (L) Advanced airway devices; and
- (M) Tonsillar suction with back-up suction.

~~(4)~~(2) The following drugs are maintained with a current shelf life and with access from the operatory and recovery area:
- (A) ~~Epinephrine;~~ Injectable epinephrine;
- (B) ~~Atropine;~~ Injectable atropine;
- (C) ~~Appropriate~~ Injectable appropriate reversal agents;
- (D) ~~Antihistamine;~~ Injectable antihistamine;
- (E) ~~Corticosteroid;~~ Injectable corticosteroid;
- (F) Nitroglycerine;
- (G) ~~Bronchial dilator;~~ Bronchodilator;
- (H) ~~Antiemetic;~~ Injectable antiemetic;
- (I) Injectable 50% Dextrose; and
- (J) ~~Anti-arrythmic;~~ Injectable anti-arrythmic.

~~(5)~~(3) Written emergency and patient discharge protocols are maintained and training to familiarize ~~office personnel~~ auxiliaries in the treatment of clinical emergencies is provided; and

~~(6)~~(4) The following records are maintained for at least 10 years:
- (A) Patient's current written medical ~~history,~~ history and pre-operative assessment; ~~including known allergies and previous surgery;~~
- (B) Drugs administered during the procedure, including route of administration, dosage, strength, time and sequence of administration;
- (C) A sedation ~~record which shall include:~~record; and
  - ~~(i) blood pressure;~~
  - ~~(ii) pulse rate;~~
  - ~~(iii) respiration;~~
  - ~~(iv) duration of procedure;~~
  - ~~(v) documentations of complications or morbidity; and~~
  - ~~(vi) status of patient upon discharge.~~
- (D) Signed consent form, identifying the procedure, risks and benefits, level of sedation and date signed.

(5) The sedation record shall include:
- (A) base line vital signs, blood pressure (unless patient behavior prevents recording); oxygen saturation, ET CO2, pulse and respiration rates recorded in real time at 15 minute intervals;
- (B) procedure start and end times;
- (C) gauge of needle and location of IV, if used;
- (D) status of patient upon discharge; and

(E) documentation of complications or morbidity.

(6) The following conditions shall be satisfied during a sedation procedure:

(A) Two BLS certified auxiliaries shall be present at all times during the procedure, one of whom shall be dedicated to continuous patient monitoring and recording sedation data.

(B) If IV sedation is used, IV infusion shall be administered before the start of the procedure and maintained until the patient is ready for dismissal.

(b) During an inspection or evaluation, the applicant or permit holder shall demonstrate the administration of moderate conscious sedation on a patient, ~~or where applicable, moderate pediatric conscious sedation on a patient,~~ including the deployment of an intravenous delivery system, while the evaluator observes. ~~Practices limited to pediatric dentistry will not be required to demonstrate the deployment of an intravenous delivery system. Instead, they will orally describe to the evaluator the technique of their training in intravenous and intraosseous deployment.~~ During the demonstration, the applicant or permit holder shall demonstrate competency in the following areas:

(1) Monitoring blood pressure, pulse, ET CO2 and respiration;

(2) Drug dosage and administration;

(3) Treatment of untoward reactions including respiratory or cardiac depression if applicable;

(4) Sterile technique;

(5) Use of BLS ~~CPR~~ certified ~~personnel;~~ auxiliaries;

(6) Monitoring of patient during recovery; and

(7) Sufficiency of patient recovery time.

(c) During an inspection or evaluation, the applicant or permit holder shall verbally demonstrate competency to the evaluator in the treatment of the following clinical emergencies:

(1) Laryngospasm;

(2) Bronchospasm;

(3) Emesis and aspiration;

(4) Respiratory depression and arrest;

(5) Angina pectoris;

(6) Myocardial infarction;

(7) ~~Hypertension/Hypotension;~~ Hypertension and Hypotension;

(8) Syncope;

(9) Allergic reactions;

(10) Convulsions;

(11) Bradycardia;

(12) Insulin shock; ~~and~~

(13) Cardiac ~~arrest~~. arrest; and

(14) Airway obstruction.

~~(d) A dentist administering moderate conscious sedation or moderate pediatric conscious sedation shall ensure that the facility is staffed with sufficient auxiliary personnel for each procedure performed who shall document annual successful completion of basic life support training and be capable of assisting with procedures, problems, and emergency incidents that may occur as a result of the sedation or secondary to an unexpected medical complication.~~

(d) A moderate conscious sedation permit holder shall evaluate patients for health risks before starting any sedation procedure as follows:

(1) A patient who is medically stable and who is ASA I or II shall be evaluated by reviewing the patient's current medical history and medication use.

(2) Patients who are not medically stable or who are ASA III or higher shall be evaluated by a consultation with the patient's primary care physician or consulting medical specialist regarding the potential risks posed by the procedure.

(e) Post-operative monitoring and discharge:

(1) Vital signs shall be continuously monitored when the sedation is no longer being administered and the patient shall have direct continuous supervision until oxygenation and circulation are stable and the patient is sufficiently responsive for discharge from the office.

(2) Recovery from moderate conscious sedation shall include:

(A) cardiovascular function stable;

(B) airway patency uncompromised;

(C) patient easily arousable and protective reflexes intact;

(D) state of hydration within normal limits;

(E) patient can talk, if applicable;

(F) patient can sit unaided, if applicable;

(G) patient can ambulate, if applicable, with minimal assistance; and

(H) for the patient who is disabled, or incapable of the usually expected responses, the pre-sedation level of responsiveness or the level as close as possible for that patient shall be achieved.

(3) Before allowing the patient to leave the office, the dentist shall determine that the patient has met the recovery criteria set out in Subparagraph (e)(2) of this Rule and the following discharge criteria:

(A) oxygenation, circulation, activity, skin color and level of consciousness are sufficient and stable and have been documented;

(B) explanation and documentation of written postoperative instructions have been provided to the patient or a responsible adult at time of discharge; and

(C) responsible individual is available for the patient to transport the patient after discharge.

Authority G.S. 90-28; 90-30.1; 90-48.

21 NCAC 16Q .0303 TEMPORARY APPROVAL PRIOR TO SITE INSPECTION

~~(a) If a dentist meets the requirements of Paragraphs (a) – (e) of Rule .0301 of this Subchapter, he/she shall be granted temporary approval to administer moderate conscious sedation, or moderate pediatric conscious sedation until a permit can be issued. If a dentist meets the requirements of Paragraph (j) of Rule .0301 of this Subchapter, he/she shall be granted temporary approval to administer moderate conscious sedation limited to oral routes and nitrous oxide inhalation. Temporary approval may be granted based solely on credentials until all processing and investigation has been completed. The temporary approval will expire after 90 days. In its discretion and for good cause, the Board may extend the temporary approval for an additional 90 days. No other extensions will be granted. An applicant who fails to complete the live patient practice requirements within the time allowed by this Rule must re apply for a permit and will not be eligible for temporary approval. An on site evaluation of the facilities, equipment, procedures, and personnel shall be required prior to issuance of a permanent permit. The evaluation shall be conducted in accordance with Rules .0204 – .0205 of this Subchapter, except that evaluations of dentists applying for moderate conscious sedation permits may be conducted by dentists who have been issued moderate conscious sedation permits by the Board and who have been approved by the Board, as set out in these Rules. A two hundred seventy five dollar ($275.00) inspection fee shall be collected for each site inspected pursuant to this Rule.~~

~~(b) An inspection may be made upon renewal of the permit or for cause.~~

~~(c) Temporary approval shall not be granted to a provisional licensee or applicants who are subject of a pending Board disciplinary investigation or whose licenses have been revoked, suspended or are subject to an order of stayed suspension or probation.~~

Authority G.S. 90-28; 90-30.1.

21 NCAC 16Q .0304 OFF SITE USE OF MODERATE CONSCIOUS SEDATION PERMITS

(a) ~~Upon request, the~~ The holder of a ~~moderate pediatric conscious sedation or~~ moderate conscious sedation permit may travel to the office of a licensed dentist who does not hold such a permit and provide moderate conscious sedation ~~services at the level for which the traveling dentist holds a valid permit, as well as minimal sedation or moderate conscious sedation limited to oral routes~~ for the patients of that dentist who are undergoing dental procedures. The permit holder shall ensure~~is solely responsible for providing~~ that the facility in which the sedation is administered has passed inspection by the Board and meets the requirements set out in Rule .0302 of this Section. ~~established by the Board, that the required drugs and equipment are present, and that the~~ The permit holder shall ensure that ~~utilizes sufficient auxiliary personnel for each procedure performed based on the standard of care who shall document annual successful completion of basic life support training~~ two BLS certified auxiliaries are available for each procedure. ~~and be capable of assisting with procedures, problems, and emergency incidents that may occur as a result of the sedation or secondary to an unexpected medical complication.~~

~~(b) Holders of moderate conscious sedation permits limited to oral routes and nitrous oxide inhalation may not provide sedation at the office of a licensed dentist who does not hold an appropriate sedation permit.~~

Authority G.S. 90-28; 90-30; 90-48.

21 NCAC 16Q .0305 ANNUAL RENEWAL OF MODERATE CONSCIOUS SEDATION PERMIT REQUIRED

(a) Moderate conscious sedation permits shall be renewed by the Board annually at the same time as dental licenses by paying a one hundred dollar ($100.00) fee and completing an application available from the Board's website: www.ncdentalboard.org.

(b) If the completed permit renewal application and renewal fee are not received before January 31 of each year, a one hundred dollar ($100.00) late fee shall be paid.

(c) Any dentist who fails to renew a moderate conscious sedation permit before March 31 of each year shall complete a reinstatement application, pay the renewal fee, late fee and comply with all conditions for renewal set out in this Rule. Dentists whose sedation permits have been lapsed for more than 12 calendar months shall pass a facilities inspection and an evaluation as part of the reinstatement process.

(d) A dentist who administers moderate conscious sedation in violation of this Rule shall be subject to the penalties prescribed by Rule .0701 of this Subchapter.

(e) As a condition for renewal of the moderate conscious sedation permit the applicant shall meet the clinical equipment requirements of Rule .0302 of this Section and shall document:

(1) six hours of continuing education each year in one or more of the following areas, which may be counted toward fulfillment of the continuing education required each calendar year for license renewal:
  (A) sedation;
  (B) medical emergencies;
  (C) monitoring IV sedation and the use of monitoring equipment;
  (D) pharmacology of drugs and agents used in IV sedation;
  (E) physical evaluation, risk assessment, or behavioral management; or
  (F) airway management; and

(2) current ACLS, which shall not count towards the six hours of continuing education required in Subparagraph (e)(1) of this Rule.

(3) that the permit holder and all auxiliaries have practiced responding to dental emergencies as a

team at least once every six months in the preceding year;

(4) that the permit holder and all auxiliaries have read the practice's emergency manual in the preceding year; and

(5) that all auxiliaries have completed BLS and six hours of continuing education in medical emergencies annually.

(f) All applicants for renewal of a moderate conscious sedation permit shall be in good standing with the Board.

Authority G.S. 90-28; 90-30.1; 90-48.

21 NCAC 16Q .0306 PROCEDURE FOR MODERATE CONSCIOUS SEDATION EVALUATION OR INSPECTION AND REINSPECTION

(a) When an evaluation or on-site inspection is required, the Board will designate one or more qualified persons, each of whom has administered moderate conscious sedation for at least three years preceding the inspection, exclusive of his or her training in moderate conscious sedation.

(b) An inspection fee of three hundred seventy five dollars ($375.00) shall be due 10 days after the dentist receives notice of the inspection of each additional location at which the dentist administers moderate conscious sedation.

(c) Any dentist-member of the Board may observe or consult in any evaluation.

(d) The inspection team shall determine compliance with the requirements of the Rules in this Subchapter, as applicable, by assigning a grade of "pass" or "fail.

(e) Each evaluator shall report his or her recommendation to the Board's Anesthesia and Sedation Committee, setting forth the details supporting his or her conclusion. The Committee is not bound by these recommendations. The Committee shall determine whether the applicant has passed the evaluation or inspection and shall notify the applicant in writing of its decision.

(f) An applicant who fails an inspection or evaluation shall not receive a permit to administer moderate conscious sedation. If a permit holder fails an evaluation, the permit will be summarily suspended. If a permit holder's facility fails an inspection, no further sedation procedures may be performed at the facility until it passes a re-inspection by the Board.

(g) An applicant who fails an inspection or evaluation may request a re-evaluation or re-inspection within 15 days of receiving the notice of failure. The request shall include a statement of the grounds supporting the re-evaluation or re-inspection. The Board shall require the applicant to receive additional training prior to the re-evaluation to address the areas of deficiency determined by the evaluation.

(h) Re-evaluations and re-inspections shall be conducted by Board-appointed evaluators not involved in the failed evaluation or inspection.

Authority G.S. 90-28; 90-30.1; 90-39.

SECTION .0400 - ENTERAL CONSCIOUS SEDATION

21 NCAC 16Q .0401 MINIMAL CONSCIOUS SEDATION CREDENTIALS, EVALUATION AND PERMIT

~~(a) Before a dentist licensed to practice in North Carolina may administer or supervise a certified registered nurse anesthetist to administer minimal conscious sedation, the dentist shall obtain a Board issued permit for minimal conscious sedation, moderate pediatric conscious sedation, moderate conscious sedation or general anesthesia. A permit is not required for prescription administration of DEA controlled drugs prescribed for postoperative pain control intended for home use. A dentist may obtain a minimal conscious sedation permit from the Board by completing an application form provided by the Board and paying a fee of one hundred dollars ($100.00). Such permit must be renewed annually and shall be displayed with the current renewal at all times in a conspicuous place in the office of the permit holder.~~

~~(b) Only a dentist who holds a general anesthesia license may administer deep sedation or general anesthesia.~~

~~(c) Application:~~

~~(1) A minimal conscious sedation permit may be obtained by completing an application form provided by Board, a copy of which may be obtained from the Board office, and meeting the requirements of Section .0400 of this Subchapter.~~

~~(2) The application form must be filled out completely and appropriate fees paid.~~

~~(3) An applicant for a minimal conscious sedation permit shall be licensed and in good standing with the Board in order to be approved. For purposes of these Rules "good standing" means that the applicant is not subject to a disciplinary investigation and his or her licensee has not been revoked or suspended and is not subject to a probation or stayed suspension order.~~

~~(d) Evaluation:~~

~~(1) Prior to issuance of a minimal conscious sedation permit the applicant shall undergo a facility inspection. The Board shall direct an evaluator qualified to administer minimal sedation to perform this inspection. The applicant shall be notified in writing that an inspection is required and provided with the name of the evaluator who shall perform the inspection. The applicant shall be responsible for successful completion of inspection of his or her facility within three months of notification. An extension of no more than 90 days shall be granted if the designated evaluator or applicant requests one.~~

~~(2) During an inspection or evaluation, the applicant or permit holder shall demonstrate competency in the following areas:~~

~~(A) Monitoring of blood pressure, pulse, pulse oximetry and respiration;~~

~~(B) Drug dosage and administration (by verbal demonstration);~~

(C) Treatment of untoward reactions including respiratory or cardiac depression (by verbal demonstration);
(D) Sterilization;
(E) Use of CPR certified personnel;
(F) Monitoring of patient during recovery (by verbal demonstration); and
(G) Sufficiency of patient recovery time (by verbal demonstration).

(3) During an inspection or evaluation, the applicant or permit holder shall verbally demonstrate competency to the evaluator in the treatment of the following clinical emergencies:
(A) Laryngospasm;
(B) Bronchospasm;
(C) Emesis and aspiration;
(D) Respiratory depression and arrest;
(E) Angina pectoris;
(F) Myocardial infarction;
(G) Hypertension/Hypotension;
(H) Syncope;
(I) Allergic reactions;
(J) Convulsions;
(K) Bradycardia;
(L) Insulin shock; and
(M) Cardiac arrest.

(4) The evaluator shall assign a grade of pass or fail and shall report his recommendation to the Board, setting out the basis for his conclusion. The Board is not bound by the evaluator's recommendation and shall make a final determination regarding whether the applicant has passed the evaluation. The applicant shall be notified of the Board's decision in writing.

(c) Educational/Professional Requirements:

(1) The dentist applying for a minimal conscious sedation permit shall meet one of the following criteria:
(A) successful completion of training consistent with that described in Part I or Part III of the American Dental Association (ADA) Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry, and have documented administration of minimal conscious sedation in a minimum of five cases;
(B) successful completion of an ADA accredited post doctoral training program which affords comprehensive training necessary to administer and manage minimal conscious sedation;
(C) successful completion of an 18 hour minimal conscious sedation course which must be approved by the Board based on whether it affords comprehensive training necessary to administer and manage minimal conscious sedation;
(D) successful completion of an ADA accredited postgraduate program in pediatric dentistry; or
(E) is a North Carolina licensed dentist in good standing who has been using minimal conscious sedation in a competent manner for at least one year immediately preceding October 1, 2007 and his or her office facility has passed an on-site inspection by a Board evaluator as required in Paragraph (d) of this Rule. Competency shall be determined by presentation of successful administration of minimal conscious sedation in a minimum of five clinical cases.

(2) All applicants for a minimal sedation permit must document successful completion of a Basic Life Saving (BLS) course within the 12 months prior to the date of application.

Authority G.S. 90-28; 90-30.1.

21 NCAC 16Q .0402 MINIMAL CONSCIOUS SEDATION PERMIT REQUIREMENTS, CLINICAL PROVISIONS AND EQUIPMENT

(a) Minimal conscious sedation is indicated for use only as defined in Rule .0101(15) of this Subchapter (relating to Definitions). Minimal conscious sedation is not indicated for use to achieve deep sedation.

(b) A minimal conscious sedation permit is not required for minor psychosedatives used for anxiolysis prescribed for administration outside of the dental office when pre-procedure instructions are likely to be followed. Medication administered for the purpose of minimal conscious sedation shall not exceed the maximum doses recommended by the drug manufacturer, sedation textbooks, or juried sedation journals. Except for nitrous inhalation, drugs in combination are not permitted for minimal conscious sedation. During longer periods of minimal conscious sedation, in which the amount of time of the procedures exceeds the effective duration of the sedative effect of the drug used, the incremental doses of the sedative shall not exceed total safe dosage levels based on the effective half-life of the drug used.

(c) Each dentist shall:

(1) adhere to the clinical requirements as detailed in Paragraph (e) of this Rule;
(2) maintain under continuous direct supervision any auxiliary personnel, who shall be capable of assisting in procedures, problems, and emergencies incident to the use of minimal conscious sedation or secondary to an unexpected medical complication;
(3) utilize sufficient auxiliary personnel for each procedure performed who shall document

annual successful completion of basic life support training; and

(4) not allow a minimal conscious sedation procedure to be performed in his or her office by a Certified Registered Nurse Anesthetist (CRNA) unless the dentist holds a permit issued by the Board for the procedure being performed. This provision addresses dentists and is not intended to address the scope of practice of persons licensed by any other agency.

(d) Each dentist shall meet the following requirements:

(1) Patient Evaluation. Patients who are administered minimal conscious sedation must be evaluated for medical health risks prior to the start of any sedative procedure. A patient receiving minimal conscious sedation must be healthy or medically stable (ASA I, or ASA II as defined by the American Society of Anesthesiologists). An evaluation is a review of the patient's current medical history and medication use. However, for individuals who are not medically stable or who have a significant health disability Physical Status III (ASA III, as defined by the American Society of Anesthesiologists) a consultation with their primary care physician or consulting medical specialist regarding potential procedure risk is required.

(2) Pre procedure preparation, informed consent:

(A) The patient or guardian must be advised of the procedure associated with the delivery of the minimal conscious sedation.

(B) Equipment must be evaluated and maintained for proper operation.

(C) Baseline vital signs shall be obtained at the discretion of the operator depending on the medical status of the patient and the nature of the procedure to be performed.

(D) Dentists administering minimal conscious sedation shall use sedative agents that he/she is competent to administer and shall administer such agents in a manner that is within the standard of care.

(e) Patient monitoring:

(1) Patients who have been administered minimal conscious sedation shall be monitored during waiting periods prior to operative procedures. An adult who has accepted responsibility for the patient and been given written pre-procedural instruction may provide such monitoring. The patient shall be monitored for alertness, responsiveness, breathing and skin coloration.

(2) Dentists administering minimal conscious sedation shall maintain direct supervision of the patient during the operative procedure and for such a period of time necessary to establish pharmacologic and physiologic vital sign stability.

(A) Oxygenation. Color of mucosa, skin or blood shall be continually evaluated. Oxygen saturation shall be evaluated continuously by pulse oximetry, except as provided in Paragraph (e)(4) of this Rule.

(B) Ventilation. Observation of chest excursions or auscultation of breath sounds or both shall be performed.

(C) Circulation. Blood pressure and pulse shall be taken and recorded initially and thereafter as appropriate except as provided in Paragraph (e)(4) of this Rule.

(D) AED. Dentists administering minimal conscious sedation shall maintain a functioning automatic external defibrillator (AED).

(3) An appropriate time oriented anesthetic record of vital signs shall be maintained in the permanent record including documentation of individual(s) administering the drug and showing the name of drug, strength and dosage used.

(4) If the dentist responsible for administering minimal conscious sedation must deviate from the requirements set out in this Rule, he or she shall document the occurrence of such deviation and the reasons for such deviation.

(f) Post operative procedures:

(1) Following the operative procedure, positive pressure oxygen and suction equipment shall be immediately available in the recovery area or operatory.

(2) Vital signs shall be continuously monitored when the sedation is no longer being administered and the patient shall have direct continuous supervision until oxygenation and circulation are stable and the patient is sufficiently responsive for discharge from the office.

(3) Patients who have adverse reactions to minimal conscious sedation shall be assisted and monitored either in an operatory chair or recovery area until stable for discharge.

(4) Recovery from minimal conscious sedation shall include:

(A) cardiovascular function stable;

(B) airway patency uncompromised;

(C) patient easily arousable and protective reflexes intact;

(D) state of hydration within normal limits;
(E) patient can talk, if applicable;
(F) patient can sit unaided, if applicable;
(G) patient can ambulate, if applicable, with minimal assistance; and
(H) for the patient who is disabled, or incapable of the usually expected responses, the pre-sedation level of responsiveness or the level as close as possible for that patient shall be achieved.

(5) Prior to allowing the patient to leave the office, the dentist shall determine that the patient has met the recovery criteria set out in Paragraph (f)(4) of this Rule and the following discharge criteria:
(A) oxygenation, circulation, activity, skin color and level of consciousness are sufficient and stable and have been documented;
(B) explanation and documentation of written postoperative instructions have been provided to the patient or a responsible adult at time of discharge;
(C) responsible individual is available for the patient to transport the patient after discharge;
(D) A vested adult must be available to transport patients for whom a motor vehicle restraint system is required and an additional responsible individual must be available to attend to the patients.

(g) The dentist, personnel and facility shall be prepared to treat emergencies that may arise from the administration of minimal conscious sedation, and shall have the ability to provide positive pressure ventilation with 100% oxygen with an age appropriate device.

Authority G.S. 90-28; 90-30.1.

21 NCAC 16Q .0403 TEMPORARY APPROVAL PRIOR TO SITE INSPECTION

(a) A dentist whose facility has not been inspected but who has otherwise met the requirements of Rule .0401 of this Section may seek temporary approval to administer minimal conscious sedation until a permit can be issued. Temporary approval may be granted based solely on credentials until all processing and investigation has been completed. Temporary approval may not exceed three months.

(b) Temporary approval shall not be granted to a provisional licensee or to an applicant who is not in good standing. he subject of a disciplinary investigation or whose license has been revoked or suspended or is the subject of a probation or stayed suspension order.

(c) A two hundred seventy five dollar ($275.00) fee shall be collected for each site inspected pursuant to Rule .0401 of this Section.

Authority G.S. 90-28; 90-30.1.

21 NCAC 16Q .0404 CREDENTIALS AND PERMITS FOR MODERATE PEDIATRIC CONSCIOUS SEDATION

(a) Before a dentist licensed to practice in North Carolina may administer moderate pediatric conscious sedation, the dentist shall obtain a general anesthesia or moderate pediatric conscious sedation permit from the Board by completing an application form and paying a fee of three hundred seventy-five dollars ($375.00). The application form is available on the Board's website: www.ncdentalboard.org. The permit shall be renewed annually and shall be displayed with the current renewal at all times in the permit holder's facility where it is visible to patients receiving treatment.

(b) A dentist applying for a permit to administer moderate pediatric conscious sedation shall meet at least one of the following criteria:
(1) completion of a postgraduate program which included pediatric intravenous conscious sedation training;
(2) completion of a Council On Dental Accreditation (CODA) approved pediatric residency which included intravenous conscious sedation training;
(3) completion of a pediatric degree or pediatric residency at a CODA approved institution that includes training in the use and placement of IVs or intraosseous vascular access.

(c) All applicants for moderate pediatric conscious sedation permits shall have completed the training required by Paragraph (b) of this Rule within the last two years or show evidence of moderate pediatric conscious sedation practice within the last two years in another state or U.S. Territory.

(d) All applicants for moderate pediatric conscious sedation permits shall be in good standing with the Board.

(e) Before receiving a moderate pediatric sedation permit, the applicant shall pass an evaluation and a facility inspection. The Board shall direct an evaluator to perform this evaluation and inspection. The Board shall notify the applicant in writing that an evaluation and facility inspection is required and provided with the name of the evaluator who shall perform the evaluation and facility inspection at least 15 days before the inspection and evaluation. The applicant shall be responsible for successful completion of the evaluation and inspection of his or her facility within 90 days of notification. An extension of no more than 90 days shall be granted if the designated evaluator or applicant requests one.

(f) An additional fee of three hundred seventy five dollars ($375.00) shall be due 10 days after the applicant receives notice of the inspection of each additional location at which the dentist administers sedation.

(g) The evaluator shall assign a grade of pass or fail and shall report his or her recommendation to the Board, setting out the basis for his or her conclusion. The Board's Anesthesia and

Sedation Committee is not bound by the evaluator's recommendation and shall make a final determination regarding whether the applicant has passed the evaluation. The applicant shall be notified of the Committee's decision in writing.

(h) An applicant who fails an inspection or an evaluation shall not receive a sedation permit.

(i) An applicant who fails an inspection or evaluation may request a re-evaluation within 15 days of receiving the notice of failure. The request shall state specific grounds supporting it. The Board shall require the applicant to receive additional training prior to the re-evaluation to address the areas of deficiency determined by the evaluation.

(j) Re-inspections shall be conducted by evaluators not involved in the failed inspection or evaluation.

(k) An applicant who does not pass the evaluation and inspection within the time allowed by Paragraph (g) of this Rule shall reapply and pay an additional three hundred seventy five dollar ($375.00) fee.

(l) A dentist who holds a moderate pediatric conscious sedation permit shall not intentionally administer deep sedation.

Authority G.S. 90-28; 90-30.1.

21 NCAC 16Q .0405 MODERATE PEDIATRIC CONSCIOUS SEDATION CLINICAL REQUIREMENTS AND EQUIPMENT

(a) A dentist administering moderate pediatric conscious sedation shall ensure that the facility in which the sedation is to be administered meets the following requirements:

(1) The facility is equipped with:
- (A) An operatory of size and design to permit access of emergency equipment and personnel and to permit effective emergency management;
- (B) A CPR board or a dental chair without enhancements, suitable for providing emergency treatment;
- (C) Lighting as necessary for specific procedures and back-up lighting; and
- (D) Suction equipment as necessary for specific procedures, including non-electrical back-up suction.

(2) The following equipment is maintained:
- (A) Positive oxygen delivery system, including full face masks for adults and pediatric patients and back-up E-cylinder portable oxygen tank apart from the central system;
- (B) Oral and nasal airways of various sizes;
- (C) Blood pressure monitoring device;
- (D) Pulse oximeter;
- (E) Capnograph;
- (F) Defibrillator;
- (G) EKG Monitor;
- (H) Thermometer;
- (I) Vascular access set-up as necessary for specific procedures, including hardware and fluids;
- (J) Syringes as necessary for specific procedures;
- (K) Advanced airways; and
- (L) Tourniquet and tape.

(3) The following drugs are maintained with a current shelf life and with access from the operatory and recovery area:
- (A) Epinephrine;
- (B) Atropine;
- (C) Appropriate reversal agents;
- (D) Antihistamine;
- (E) Corticosteroid;
- (F) Nitroglycerine;
- (G) Bronchodilator;
- (H) Antiemetic; and
- (I) 50% Dextrose.

(4) Written emergency and patient discharge protocols are maintained and training to familiarize auxiliaries in the treatment of clinical emergencies is provided; and

(5) The following records are maintained for at least 10 years:
- (A) Patient's current written medical history and pre-operative assessment;
- (B) Drugs administered during the procedure, including route of administration, dosage, strength, time and sequence of administration;
- (C) A sedation record;
- (D) Signed consent form, identifying the procedure, risks and benefits, level of sedation and date signed.

(6) The sedation record shall include:
- (A) base line vital signs, blood pressure (unless patient behavior prevents recording); oxygen saturation, ET CO2, pulse and respiration rates recorded in real time at 15 minute intervals;
- (B) procedure start and end times;
- (C) gauge of needle and location of IV, if used;
- (D) status of patient upon discharge; and
- (E) documentation of complications or morbidity.

(7) The following conditions shall be satisfied during a sedation procedure:
- (A) Two BLS certified auxiliaries shall be present at all times during the procedure, one of whom shall be dedicated to patient monitoring and recording sedation data.
- (B) When IV sedation is used, IV infusion shall be administered before the commencement of the procedure and

maintained until the patient is ready for dismissal.

(b) During an inspection or evaluation, applicants and permit holders who use intravenous sedation shall demonstrate the administration of moderate pediatric conscious sedation on a live patient, including the deployment of an intravenous delivery system, while the evaluator observes. Applicants and permit holders who do not use IV sedation shall describe the proper deployment of an intravenous delivery system to the evaluator and shall demonstrate the administration of moderate pediatric conscious sedation on a live patient while the evaluator observes.

(c) During the demonstration, all applicants and permit holders shall demonstrate competency in the following areas:

(1) Monitoring blood pressure, temperature, pulse, and respiration;
(2) Drug dosage and administration;
(3) Treatment of any untoward reactions including respiratory or cardiac depression;
(4) Sterile technique;
(5) Use of BLS certified auxiliaries;
(6) Monitoring of patient during recovery; and
(7) Sufficiency of patient recovery time.

(d) During an inspection or evaluation, the applicant or permit holder shall verbally demonstrate competency in treating the following clinical emergencies:

(1) Laryngospasm;
(2) Bronchospasm;
(3) Emesis and aspiration;
(4) Respiratory depression and arrest;
(5) Angina pectoris;
(6) Myocardial infarction;
(7) Hypertension and Hypotension;
(8) Allergic reactions;
(9) Convulsions;
(10) Syncope;
(11) Bradycardia;
(12) Insulin shock;
(13) Cardiac arrest;
(14) Airway obstruction; and
(15) Vascular access.

(e) A moderate pediatric conscious sedation permit holder shall evaluate patients for health risks before starting any sedation procedure as follows:

(1) A patient who is medically stable and who is ASA I or II shall be evaluated by reviewing the patient's current medical history and medication use.
(2) Patients who are not medically stable or who are ASA III or higher shall be evaluated by a consultation with the patient's primary care physician or consulting medical specialist regarding the potential risks posed by the procedure.

(f) Patient monitoring:

(1) Patients who have been administered moderate pediatric conscious sedation shall be monitored for alertness, responsiveness, breathing and skin coloration during waiting periods before operative procedures.
(2) Vital signs shall be continuously monitored when the sedation is no longer being administered and the patient shall have direct continuous supervision until oxygenation and circulation are stable and the patient is sufficiently responsive for discharge from the office.
(3) Recovery from moderate pediatric conscious sedation shall include:
(A) cardiovascular function stable;
(B) airway patency uncompromised;
(C) patient easily arousable and protective reflexes intact;
(D) state of hydration within normal limits;
(E) patient can talk, if applicable;
(F) patient can sit unaided, if applicable;
(G) patient can ambulate, if applicable, with minimal assistance; and
(H) for the patient who is disabled, or incapable of the usually expected responses, the pre-sedation level of responsiveness or the level as close as possible for that patient shall be achieved.
(4) Before allowing the patient to leave the office, the dentist shall determine that the patient has met the recovery criteria set out in Subparagraph (f)(3) of this Rule and the following discharge criteria:
(A) oxygenation, circulation, activity, skin color and level of consciousness are sufficient and stable and have been documented;
(B) explanation and documentation of written postoperative instructions have been provided to a responsible adult at time of discharge;
(C) responsible individual is available for the patient to transport the patient after discharge; and
(D) A vested adult shall be available to transport patients for whom a motor vehicle restraint system is required and an additional responsible individual shall be available to attend to the patients.

Authority G.S. 90-28; 90-30.1; 90-48.

21 NCAC 16Q .0406 OFF SITE USE OF MODERATE PEDIATRIC CONSCIOUS SEDATION PERMITS

The holder of a moderate pediatric conscious sedation permit may travel to the office of a licensed dentist and provide moderate pediatric conscious sedation. The permit holder shall ensure that

the facility where the sedation is administered has been inspected by the Board as required by Rule .0404 of this Section and that the equipment, facility and auxiliaries meet the requirements of Rule .0405 of this Section.

Authority G.S. 90-28; 90-30; 90-48.

21 NCAC 16Q .0407 ANNUAL RENEWAL OF MODERATE PEDIATRIC CONSCIOUS SEDATION PERMIT REQUIRED

(a) Moderate pediatric conscious sedation permits shall be renewed by the Board annually at the same time as dental licenses by paying a one hundred dollar ($100.00) fee and completing an application available from the Board's website: www.ncdentalboard.org.

(b) If the completed renewal application and renewal fee are not received before January 31 of each year, a one hundred dollar ($100.00) late fee shall be paid.

(c) Any dentist who fails to renew a moderate pediatric conscious sedation permit before March 31 of each year shall complete a reinstatement application, pay the renewal fee, late fee and comply with all conditions for renewal set out in this Rule. Dentists whose sedation permits have been lapsed for more than 12 calendar months shall pass a facilities inspection and an evaluation as part of the reinstatement process.

(d) Continued administration of level of sedation in violation of this Rule shall be unlawful and shall subject the dentist to the penalties prescribed by Rule .0701 of this Subchapter.

(e) As a condition for renewal of the moderate pediatric conscious sedation permit, the permit holder shall meet the clinical and equipment requirements of Rule .0405 of this Section and:

(1) document six hours of continuing education each year in one or more of the following areas, which may be counted toward fulfillment of the continuing education required each calendar year for license renewal:
  (A) sedation;
  (B) medical emergencies;
  (C) monitoring IV sedation and the use of monitoring equipment;
  (D) pharmacology of drugs and agents used in IV sedation;
  (E) physical evaluation, risk assessment, or behavioral management; or
  (F) airway management; and

(2) document current PALS, which shall not count towards the six hours of continuing education required in Subparagraph (e)(1) of this Rule;

(3) document that the permit holder and all auxiliaries have practiced responding to dental emergencies as a team at least once every six months in the preceding year.

(4) document that the permit holder and all auxiliaries have read the practice's emergency manual in the preceding year.

(5) document that all auxiliaries have completed BLS and six hours of continuing education in medical emergencies annually.

(f) All applicants for renewal of a moderate pediatric conscious sedation permit shall be in good standing with the Board.

Authority G.S. 90-28; 90-30.1; 90-48.

21 NCAC 16Q .0408 PROCEDURE FOR MODERATE PEDIATRIC SEDATION EVALUATION OR INSPECTION AND REINSPECTION

(a) When an evaluation or on-site inspection is required, the Board will designate one or more qualified persons, each of whom has administered moderate pediatric sedation for at least three years preceding the inspection, exclusive of his or her training in moderate pediatric sedation.

(b) An inspection fee of three hundred seventy five dollars ($375.00) shall be due 10 days after the dentist receives notice of the inspection of each additional location at which the dentist administers moderate pediatric sedation.

(c) Any dentist-member of the Board may observe or consult in any evaluation.

(d) The inspection team shall determine compliance with the requirements of the Rules in this Subchapter, as applicable, by assigning a grade of "pass" or "fail.

(e) Each evaluator shall report his or her recommendation to the Board's Anesthesia and Sedation Committee, setting forth the details supporting his or her conclusion. The Committee is not bound by these recommendations. The Committee shall determine whether the applicant has passed the evaluation or inspection and shall notify the applicant in writing of its decision.

(f) An applicant who fails an inspection or evaluation shall not receive a permit to administer pediatric sedation. If a permit holder fails an evaluation, the permit will be summarily suspended. If a permit holder's facility fails an inspection, no further sedation procedures may be performed at the facility until it passes a re-inspection by the Board.

(g) An applicant who fails an inspection or evaluation may request a re-evaluation or re-inspection within 15 days of receiving the notice of failure. The request shall include a statement of the grounds supporting the re-evaluation or re-inspection. The Board shall require the applicant to receive additional training prior to the re-evaluation to address the areas of deficiency determined by the evaluation.

(h) Re-evaluations and re-inspections shall be conducted by Board-appointed evaluators not involved in the failed evaluation or inspection.

Authority G.S. 90-28; 90-30.1; 90-39.

SECTION .0500 - MODERATE CONSCIOUS SEDATION LIMITED TO ORAL ROUTES AND NITROUS OXIDE

21 NCAC 16Q .0501 ANNUAL RENEWAL REQUIRED

~~(a) General anesthesia and all sedation permits shall be renewed by the Board annually. Such renewal shall be accomplished in conjunction with the license renewal process, and applications for permits shall be made at the same time as applications for renewal of licenses. A one hundred ($100.00) annual renewal fee shall be paid at the time of renewal.~~

(b) All sedation permits shall be subject to the same renewal deadlines as are dental practice licenses, in accordance with G.S. 90-31. If the permit renewal application is not received by the date specified in G.S. 90-31, continued administration of general anesthesia or any level of conscious sedation shall be unlawful and shall subject the dentist to the penalties prescribed by Section .0700 of this Subchapter.

(c) As a condition for renewal of the general anesthesia permit, the permit holder shall meet the requirements of 21 NCAC 16Q .0202 and document current, successful completion of advanced cardiac life support (ACLS) training, or its age-specific equivalent or other equivalent course, and auxiliary personnel shall document annual, successful completion of basic life support (BLS) training.

(d) As a condition for renewal of the moderate conscious sedation permit or moderate pediatric conscious sedation permit, the permit holder shall meet the requirements of 21 NCAC 16Q .0302 and:

(1) document annual, successful completion of BLS training and obtain three hours of continuing education each year in one or more of the following areas, which may be counted toward fulfillment of the continuing education required each calendar year for license renewal:
  (A) sedation;
  (B) medical emergencies;
  (C) monitoring IV sedation and the use of monitoring equipment;
  (D) pharmacology of drugs and agents used in IV sedation;
  (E) physical evaluation, risk assessment, or behavioral management;
  (F) audit ACLS/Pediatric Advanced Life Support (PALS) courses; and
  (G) airway management; or
(2) document current, successful completion of ACLS training or its age-specific equivalent, or other equivalent course and annual successful completion of BLS.

(e) moderate pediatric conscious sedation permit holders must have current PALS at all times.

(f) As a condition for renewal of the minimal conscious sedation permit and the moderate conscious sedation permit limited to oral routes and nitrous oxide inhalation, the permit holder shall meet the requirements of 16Q .0402 and shall document annual, successful completion of BLS training and obtain six hours of continuing education every two years in one or more of the following areas, which may be counted toward fulfillment of the continuing education required each calendar year for license renewal:

(1) pediatric or adult sedation;
(2) medical emergencies;
(3) monitoring sedation and the use of monitoring equipment;
(4) pharmacology of drugs and agents used in sedation;
(5) physical evaluation, risk assessment, or behavioral management; or
(6) audit ACLS/PALS courses; and
(7) airway management.

(g) Any dentist who fails to renew a general anesthesia or sedation permit on or before March 31 of each year must complete a reinstatement application, pay the one hundred dollar ($100.00) renewal fee and a one hundred dollar ($100.00) penalty and comply with all conditions for renewal set out in this Rule for the permit sought. Dentists whose anesthesia or sedation permits have been lapsed for more than 12 calendar months must pass a facilities inspection as part of the reinstatement process.

Authority G.S. 90-28; 90-30.1; 90-48.

21 NCAC 16Q .0502 PAYMENT OF FEES

A fee of fifty dollars ($50.00) shall accompany the permit renewal application, such fee to be separate and apart from the annual license renewal fee imposed by the Board.

Authority G.S. 90-28; 90-30.1.

21 NCAC 16Q .0503 INSPECTION AUTHORIZED

Incident to the renewal of an anesthesia or sedation permit, for cause or routinely at reasonable time intervals in order to ensure compliance, the Board may require an on-site inspection of the dentist's facility, equipment, personnel and procedures. Such inspection shall be conducted in accordance with Rules .0204, .0205, .0303, and .0401 of this Subchapter.

Authority G.S. 90-28; 90-30.1.

SECTION .0600 - REPORTING AND PENALTIES

21 NCAC 16Q .0601 REPORTS OF ADVERSE OCCURRENCES

(a) A dentist who holds a permit to administer general anesthesia or sedation shall submit a report to the Board within 72 hours after each adverse occurrence related to the administration of general anesthesia or sedation which results in the death of a patient within 24 hours of the procedure.

(b) A dentist who holds a permit to administer general anesthesia or sedation shall report to the Board, within 30 days after each adverse occurrence related to the administration of general anesthesia or sedation, any situation which results in permanent organic brain dysfunction of a patient within 24 hours of the procedure or which results in physical injury causing hospitalization of a patient within 24 hours of the procedure.

(c) The adverse occurrence report shall be in writing and shall include:

(1) The dentist's name, license number and permit number;
(2) The date and time of the occurrence;
(3) The facility where the occurrence took place;
(4) The name and address of the patient;
(5) The surgical procedure involved;
(6) The type and dosage of sedation or anesthesia utilized in the procedure; and
(7) The circumstances involved in the occurrence.

~~(d) Upon receipt of any such report, the Board shall make such investigation as it deems appropriate and shall take such action as it deems necessary.~~

Authority G.S. 90-28; 90-30.1; 90-41.

21 NCAC 16Q .0602 FAILURE TO REPORT

~~If a dentist fails to report any incident as required by these Rules, the dentist shall be subject to discipline in accordance with Section .0700 of this Subchapter.~~

Authority G.S. 90-28; 90-30.1; 90-41.

SECTION .0700 - INSPECTIONS, REPORTS AND PENALTY FOR NON-COMPLIANCE

21 NCAC 16Q .0702 INSPECTION AUTHORIZED

(a) The Board may inspect the facility, equipment, auxiliaries, records or procedures of any general anesthesia, itinerant general anesthesia permit holder or sedation permit holder, with or without, cause to ensure compliance with this Subchapter. The inspections shall be conducted in accordance with Rules .0204, .0205, .0303 and .0401 of this Subchapter.

(b) The Board shall inspect every general anesthesia and sedation permit holder's facility and records at least once every five years, in accordance with Rule .0405 of this Subchapter.

(c) The Board shall annually inspect the facility and records of all general anesthesia and sedation permit holders who have held a permit for less than five years.

(d) The Board shall suspend the permit of any general anesthesia, itinerant general anesthesia or sedation permit holder who fails any inspection. No anesthesia or sedation procedures shall be performed at the failed facility site until a re-inspection is performed and a new permit is issued.

Authority G.S. 90-28; 90-30.1.

21 NCAC 16Q .0703 REPORTS OF ADVERSE OCCURRENCES

(a) A dentist who holds a permit to administer general anesthesia or sedation shall report to the Board within 72 hours after each adverse occurrence related to the administration of general anesthesia or sedation which results in the death of a patient within 24 hours of the procedure. Sedation permit holders shall cease administration of sedation until the Board has investigated the death and approved resumption of permit privileges. General anesthesia permit holders shall cease administration of general anesthesia and sedation until the Board has reviewed the incident report and approved resumption of permit privileges.

(b) A dentist who holds a permit to administer general anesthesia or sedation shall report to the Board within 30 days after each adverse occurrence related to the administration of general anesthesia or sedation which results in permanent organic brain dysfunction of a patient occurring within 24 hours of the procedure or which results in physical injury or severe medical emergencies, causing hospitalization of a patient occurring within 24 hours of the procedure.

(c) The adverse occurrence report shall be in writing and shall include:

(1) The dentist's name, license number and permit number;
(2) The date and time of the occurrence;
(3) The facility where the occurrence took place;
(4) The name and address of the patient;
(5) The surgical procedure involved;
(6) The type and dosage of sedation or anesthesia utilized in the procedure;
(7) The circumstances involved in the occurrence; and
(8) The anesthesia records.

(d) Upon receipt of any such report, the Board shall investigate and shall take disciplinary action if the evidence demonstrates that a licensee has violated the Dental Practice Act.

Authority G.S. 90-28; 90-30.1; 90-41.

*This Section includes a listing of rules approved by the Rules Review Commission followed by the full text of those rules. The rules that have been approved by the RRC in a form different from that originally noticed in the Register or when no notice was required to be published in the Register are identified by an * in the listing of approved rules. Statutory Reference: G.S. 150B-21.17.*

Rules approved by the Rules Review Commission at its meeting on May 21, 2015.

		REGISTER CITATION TO THE NOTICE OF TEXT
CHILD CARE COMMISSION		
Application for a License for a Child Care Center	10A NCAC 09 .0302*	28:19 NCR
General Safety Requirements	10A NCAC 09 .0604*	28:19 NCR
Emergency Preparedness and Response	10A NCAC 09 .0607*	28:19 NCR
In-Service Training Requirements	10A NCAC 09 .0707*	28:19 NCR
General Provisions Related to Licensure of Homes	10A NCAC 09 .1701*	28:19 NCR
Health and Training Requirements for Family Child Care Ho...	10A NCAC 09 .1705*	28:19 NCR
Safety, Medication, and Sanitation Requirements	10A NCAC 09 .1720*	28:19 NCR
Requirements for Records	10A NCAC 09 .1721*	28:19 NCR
Retention of Forms and Reports by a Child Care Operator	10A NCAC 09 .2318*	28:19 NCR
Quality Points Options	10A NCAC 09 .2829*	28:19 NCR
SOCIAL SERVICES COMMISSION		
Scope and Purpose	10A NCAC 73A .0101	29:16 NCR
Definitions	10A NCAC 73A .0102*	29:16 NCR
Drug Testing	10A NCAC 73A .0103*	29:16 NCR
Drug Testing Requirements	10A NCAC 73A .0104*	29:16 NCR
Techniques and Methods	10A NCAC 73A .0105*	29:16 NCR
Confidentiality	10A NCAC 73A .0106*	29:16 NCR
JUSTICE ACADEMY		
Firearms	12 NCAC 06A .0603*	29:16 NCR
ENVIRONMENTAL MANAGEMENT COMMISSION		
Implementation Schedule for Performance Standards for New...	15A NCAC 02N .0304*	29:09 NCR
Tanks	15A NCAC 02N .0903*	29:09 NCR
Piping	15A NCAC 02N .0904*	29:09 NCR
CHIROPRACTIC EXAMINERS, BOARD OF		
Renewal of License	21 NCAC 10 .0205*	29:14 NCR
Individual-Study Continuing Education	21 NCAC 10 .0210*	29:14 NCR
DIETETICS/NUTRITION, BOARD OF		
Declaratory Rulings	21 NCAC 17 .0119*	29:14 NCR

Petitions for Adoption, Amendment or Repeal of Rules	21	NCAC 17	.0120*	29:14 NCR
Rule Making Notice	21	NCAC 17	.0121*	29:14 NCR
REFRIGERATION EXAMINERS, BOARD OF				
Office of the Board	21	NCAC 60	.0102*	n/a G.S. 150B-21.5(a)(4)

TITLE 10A – DEPARTMENT OF HEALTH AND HUMAN SERVICES

10A NCAC 09 .0302 APPLICATION FOR A LICENSE FOR A CHILD CARE CENTER

(a) The prospective licensee of a child care center, including assuring compliance with the licensing law and standards, shall apply for a license for a child care center using the form provided by the Division. The form can be found on the Division's website at http://ncchildcare.dhhs.state.nc.us/general/mb_customerservice.asp. If the operator will be a group, organization, or other entity, an officer of the entity shall complete and sign the application.

(b) The applicant shall arrange for inspections of the center by the local health, building, and fire inspectors. The applicant shall provide to the Division copies of inspection reports pursuant to G.S. 110-91(1), (4), and (5). When a center does not conform with a building, fire, or sanitation standard, the inspector may submit a written explanation of how equivalent, alternative protection is provided. The Division shall accept the inspector's documentation in lieu of compliance with the standard. Nothing in this Rule precludes or interferes with issuance of a provisional license pursuant to Section .0400 of this Chapter.

(c) The applicant, or the person responsible for the day-to-day operation of the center, shall be able to describe the plans for the daily program, including room arrangement, staffing patterns, equipment, and supplies, in sufficient detail to show that the center shall comply with applicable requirements for activities, equipment, and staff-child ratios for the capacity of the center and type of license requested. The applicant shall make the following written information available to the Division for review to verify compliance with provisions of this Chapter and G.S. 110, Article 7:

(1) Emergency Preparedness and Response Plan;
(2) emergency medical care plan;
(3) activity plans;
(4) discipline policy;
(5) incident reports; and
(6) incident logs.

(d) The applicant shall demonstrate to the Division that the following is available for review pursuant to 10A NCAC 09 .0304(f):

(1) staff records which include an application for employment and date of birth; documentation of education, training, and experience; medical and health records; documentation of participation in training and staff development activities; and required criminal history records check documentation;
(2) children's records which include an application for enrollment; medical and immunization records; and permission to seek emergency medical care;
(3) daily attendance records;
(4) daily records of arrival and departure times at the center for each child;
(5) records of monthly fire drills documenting the date and time of each drill, the length of time taken to evacuate the building, and the signature of the person who conducted the drill as required by NC Fire Code 405.5;
(6) records of monthly playground inspections documented on a checklist provided by the Division; A copy of the form may be found on the Division's website at http://ncchildcare.nc.gov/pdf_forms/playground.pdf.
(7) records of medication administered; and
(8) records of lockdown or shelter-in-place drills as defined in 10A NCAC 09 .0102 giving the date each drill was held, the time of day, the length of time taken to get into designated locations and the signature of the person who conducted the drill.

(e) The Division shall measure all rooms to be used for child care and shall assure that an accurate sketch of the center's floor plan is part of the application packet. The Division shall enter the dimensions of each room to be used for child care, including ceiling height, and shall show the location of the bathrooms, doors, and required exits on the floor plan.

(f) The Division shall make one or more inspections of the center and premises to assess compliance with all applicable requirements as follows:

(1) if all applicable requirements of G.S. 110, Article 7 and this Section are met, the Division shall issue the license; or
(2) if all applicable requirements of G.S. 110, Article 7 and this Section are not met, the Division may recommend issuance of a provisional license in accordance with Section .0400 of this Chapter or the Division may recommend denial of the application in accordance with Paragraph (g) of this Rule.

(g) The Secretary may deny an application for a license under the following circumstances:

(1) if any child care facility license previously held by the applicant has been denied, revoked, or summarily suspended by the Division;

(2) if the Division initiated denial, revocation, or summary suspension proceedings against any child care facility license previously held by the applicant and the applicant voluntarily relinquished the license;

(3) during the pendency of an appeal of a denial, revocation, or summary suspension of any other child care facility license held by the applicant;

(4) if the Division determines that the applicant has a relationship with an operator or former operator who held a license under an administrative action described in Subparagraphs (1), (2), or (3) of this Paragraph. As used in this Rule, an applicant has a relationship with a former operator if the former operator would be involved with the applicant's child care facility in one or more of the following ways:

(A) would participate in the administration or operation of the facility;

(B) has a financial interest in the operation of the facility;

(C) provides care to children at the facility;

(D) resides in the facility; or

(E) would be on the facility's board of directors, be a partner of the corporation, or otherwise have responsibility for the administration of the business;

(5) based on the applicant's previous non-compliance as an operator with the requirements of G.S. 110, Article 7 or this Chapter;

(6) if abuse or neglect has been substantiated against the applicant pursuant to G.S. 7B-101 or G.S. 110-105.2; or

(7) if the applicant is a disqualified child care provider or has a disqualified household member residing in the center pursuant to G.S. 110-90.2.

(h) In determining whether denial of the application for a license is warranted pursuant to Paragraph (g) of this Rule, the Division shall consider:

(1) any documentation provided by the applicant that describes the steps the applicant will take to prevent reoccurrence of noncompliance issues that led to any prior administrative action taken against a license previously held by the applicant;

(2) training certificates or original transcripts for any coursework from a nationally recognized regionally accredited institution of higher learning related to providing quality child care, and that was taken subsequent to any prior administrative action against a license previously held by the applicant. "Nationally recognized" means that every state in this nation acknowledges the validity of the coursework taken at higher education institutions that meet the requirements of one of the accrediting bodies;

(3) proof of employment in a licensed child care facility and references from the administrator or licensee of the child care facility regarding work performance;

(4) documentation of collaboration or mentorship with a licensed child care provider to obtain additional knowledge and experience related to operation of a child care facility; and

(5) documentation explaining relationships with persons meeting the criteria listed in Subparagraph (g)(4) of this Rule.

History Note: Authority G.S. 110-85; 110-86; 110-88(2); 110-88(5); 110-91; 110-91(1), (4) and (5); 110-92; 110-93; 110-99; 143B-168.3;
Eff. January 1, 1986;
Amended Eff. July 1, 2015; March 1, 2014; August 1, 2011; July 1, 2010; April 1, 2003; April 1, 2001; July 1, 1998; January 1, 1996; November 1, 1989; July 1, 1988; January 1, 1987.

10A NCAC 09 .0604 SAFETY REQUIREMENTS

(a) In child care centers, potentially hazardous items, such as archery equipment, hand and power tools, nails, chemicals, propane stoves, lawn mowers, and gasoline or kerosene, whether or not intended for use by children, shall be stored in locked areas, or shall be removed from the premises or otherwise inaccessible to children.

(b) Firearms and ammunition are prohibited in a licensed child care facility unless carried by a law enforcement officer.

(c) Electrical outlets not in use which are located in space used by the children shall be covered with safety plugs unless located behind furniture or equipment that cannot be moved by a child.

(d) Electric fans shall be mounted out of the reach of children or shall be fitted with a mesh guard to prevent access by children.

(e) All electrical appliances shall be used only in accordance with the manufacturer's instructions. For appliances with heating elements, such as bottle warmers, crock pots, irons, coffee pots, or curling irons, neither the appliance nor the cord, if applicable, shall be accessible to preschool-age children.

(f) Electrical cords shall not be accessible to infants and toddlers. Extension cords, except as approved by the local fire inspector, shall not be used. Frayed or cracked electrical cords shall be replaced.

(g) All materials used for starting fires, such as matches and lighters, shall be kept in locked storage or shall be stored out of the reach of children.

(h) Smoking is not permitted in space used by children when children are present. All smoking materials shall be kept in locked storage or out of the reach of children.

(i) Fuel burning heaters, fireplaces, and floor furnaces shall be provided with a protective screen attached securely to supports to prevent access by children and to prevent objects from being thrown into them.

(j) Plants that are toxic shall not be in indoor or outdoor space that is used by or is accessible to children.
(k) Air conditioning units shall be located so that they are not accessible to children or shall be fitted with a mesh guard to prevent objects from being thrown into them.
(l) Gas tanks shall be located so they are not accessible to the children or shall be in a protective enclosure or surrounded by a protective guard.
(m) Cribs and playpens shall be placed so that the children occupying them shall not have access to cords or ropes, such as venetian blind cords.
(n) Once a day, prior to initial use, the indoor and outdoor premises shall be checked for debris, vandalism, and broken equipment. Debris shall be removed and disposed.
(o) Plastic bags, toys, and toy parts small enough to be swallowed, and materials that can be easily torn apart such as foam rubber and styrofoam, shall not be accessible to children under three years of age, except that styrofoam plates and larger pieces of foam rubber may be used for supervised art activities and styrofoam plates may be used for food service. Latex and rubber balloons shall not be accessible to children under five years of age.
(p) When non-ambulatory children are in care, a crib or other device shall be available for evacuation in case of fire or other emergency. The crib or other device shall be fitted with wheels in order to be easily moveable, have a reinforced bottom, and shall be able to fit through the designated fire exit. For centers that do not meet institutional building code, and the exit is more than eight inches above grade, the center shall develop a plan to ensure a safe and immediate evacuation of the crib or other device. The operator shall physically demonstrate this plan to the Division for review and approval. During the required fire, lockdown, or shelter-in-place drills, an evacuation crib or other device shall be used in the manner described in the Emergency Preparedness and Response Plan as defined in 10A NCAC 09 .0607(c).
(q) A first aid kit shall always be available on site.
(r) Fire drills shall be practiced monthly in accordance with 10A NCAC 09 .0607(a) and records shall be maintained as required by 10A NCAC 09 .0302(d)(5).
(s) A "shelter in place drill" or "lockdown drill" as defined in 10A NCAC 09 .0102 shall be conducted at least every three months and records shall be maintained as required by 10A NCAC 09 .0302(8).

History Note: Authority G.S. 110-85; 110-91(3),(6); 143B-168.3;
Eff. January 1, 1991;
Amended Eff. January 1, 1996; November 1, 1991;
Temporary Amendment Eff. October 1, 1997;
Amended Eff. July 1, 2015; February 1, 2012; July 1, 2010; December 1, 2007; April 1, 2001; July 1, 1998.

10A NCAC 09 .0607 EMERGENCY PREPAREDNESS AND RESPONSE

(a) For the purposes of this Rule, the Emergency Preparedness and Response in Child Care is a session training approved by the Division on creating an Emergency Preparedness and Response Plan and practicing, responding to and recovering from emergencies in child care facilities.
(b) Existing child care facilities shall have one person on staff who has completed the Emergency Preparedness and Response in Child Care training within two years from the effective date of this Rule and within four months of a trained person's last day of employment. New facilities must have a person on staff who has completed the Emergency Preparedness and Response in Child Care training within one year of the effective date of the initial license. Documentation of completion of the training shall be maintained in the individual's personnel file.
(c) Upon completion of the Emergency Preparedness and Response in Child Care training, the trained staff shall develop the Emergency Preparedness and Response Plan. The Emergency Preparedness and Response Plan means a written plan that addresses how a child care facility will respond to both natural and man-made disasters, such as fire, tornado, flood, power failures, chemical spills, bomb threats, earthquakes, blizzards, nuclear disasters, or a dangerous person or persons in the vicinity, to ensure the safety and protection of the children and staff. This Plan must be on a template provided by the Division available at https://rmp.nc.gov/portal/#, and completed within four months of completion of the Emergency Preparedness and Response in Child Care training.
(d) The Emergency Preparedness and Response Plan shall include:

(1) written procedures for accounting for all in attendance including:
  (A) the location of the children, staff, volunteer and visitor attendance lists; and
  (B) the name of the person(s) responsible for bringing the lists in the event of an emergency.
(2) a description for how and when children shall be transported;
(3) methods for communicating with parents and emergency personnel or law enforcement;
(4) a description of how children's nutritional and health needs will be met;
(5) the relocation and reunification process;
(6) emergency telephone numbers;
(7) evacuation diagrams showing how the staff, children, and any other individuals who may be present will evacuate during an emergency;
(8) the date of the last revision of the plan;
(9) specific considerations for non-mobile children and children with special needs; and
(10) the location of a Ready to Go File. A Ready to Go File means a collection of information on children, staff and the facility, to utilize, if an evacuation occurs. The file shall include, but is not limited to, a copy of the Emergency Preparedness and Response Plan, contact information for individuals to pick-up children, each child's Application for Child Care, medication authorizations and instructions, any action plans for children with special health

care needs, a list of any known food allergies of children and staff, staff contact information, Incident Report forms, an area map, and emergency telephone numbers.

(e) The trained staff shall review the Emergency Preparedness and Response Plan annually, or when information in the plan changes, to ensure all information is current.

(f) All staff shall review the center's Emergency Preparedness and Response Plan during orientation and on an annual basis with the trained staff. Documentation of the review shall be maintained at the center in the individual's personnel file in a file designated for emergency preparedness and response plan documents.

(g) All substitutes and volunteers counted in ratio who are present shall be informed of the child care center's Emergency Preparedness and Response Plan and its location. Documentation of this notice shall be maintained in the individual personnel files.

History Note: Authority G.S. 110-85;
Eff. July 1, 2015.

10A NCAC 09 .0707 IN-SERVICE TRAINING REQUIREMENTS

(a) Each center shall assure that each new employee who is expected to have contact with children receives a minimum of 16 clock hours of on-site training and orientation within the first six weeks of employment. This training and orientation shall include:

(1) training in the recognition of the signs and symptoms of child abuse or neglect and in the employee's duty to report suspected abuse and neglect pursuant to G.S. 7B-301;
(2) review of the center's operational policies, including the center's safe sleep policy for infants, the Emergency Preparedness and Response Plan, and the emergency medical care plan;
(3) adequate supervision of children in accordance with 10A NCAC 09 .0714(f);
(4) first-hand observation of the center's daily operations;
(5) instruction in the employee's assigned duties;
(6) instruction in the maintenance of a safe and healthy environment;
(7) review of the center's purposes and goals;
(8) review of the center's personnel policies;
(9) review of the child care licensing law and rules;
(10) an explanation of the role of State and local government agencies in the regulation of child care, their impact on the operation of the center, and their availability as a resource; and
(11) an explanation of the employee's obligation to cooperate with representatives of State and local government agencies during visits and investigations.

(b) As part of the training required in Paragraph (a) of this Rule, each new employee shall complete, within the first two weeks of employment, six clock hours of the training referenced in Subparagraphs (a)(1), (a)(2), and (a)(3) of this Rule.

(c) The child care administrator and any staff who have responsibility for planning and supervising a child care facility, as well as staff who work directly with children, shall participate in in-service training activities annually, as follows:

(1) persons with a four year degree or higher advanced degree in a child care related field of study from a regionally accredited college or university shall complete five clock hours of training;
(2) persons with a two year degree in a child care related field of study from a regionally accredited college or university, or persons with a North Carolina Early Childhood Administration Credential or its equivalent shall complete eight clock hours of training;
(3) persons with a certificate or diploma in a child care related field of study from a regionally accredited college or university, or persons with a North Carolina Early Childhood Credential or its equivalent shall complete 10 clock hours of training;
(4) persons with at least 10 years documented, professional experience as a teacher, director, or caregiver in a licensed child care arrangement shall complete 15 clock hours of training; or
(5) shall complete 20 clock hours of training.

(d) For staff listed in Subparagraphs (c)(1), (c)(2), (c)(3) and (c)(4) of this Rule, basic cardiopulmonary resuscitation (CPR) training required in Rule .0705 of this Section shall not be counted toward meeting annual in-service training. First aid training may be counted once every three years.

(e) If a child care administrator or lead teacher is enrolled in coursework to meet the staff qualification requirements in G.S. 110-91(8), the individual may choose to apply for completed coursework toward meeting the annual in-service training requirement.

(f) Any staff working less than 40 hours per week may choose the option for 20 hours of in-service training, or the training requirement may be prorated as follows:

WORKING HOURS PER WEEK	CLOCK HOURS REQUIRED
0-10	5
11-20	10
21-30	15
31-40	20

History Note: Authority G.S. 110-91(11); 143B-168.3;
Eff. January 1, 1986;
Amended Eff. July 1, 2015; January 1, 2006; May 1, 2004; October 29, 1998; October 1, 1991; November 1, 1989; July 1, 1988; January 1, 1987.

10A NCAC 09 .1701 GENERAL PROVISIONS RELATED TO LICENSURE OF HOMES

(a) All family child care homes shall comply with the standards for licensure set forth in this Section. A one- star rated license shall be issued to a family child care home operator who complies with the minimum standards for a license contained in this Section and G.S. 110-91.

(b) An individual who provides care for five hours or more in a week, during planned absences of the operator, shall be at least 21 years old, have a high school diploma or GED, have completed a first aid and cardiopulmonary resuscitation (CPR) course as described in Rule .1705, Subparagraphs (a)(3), (a)(4), (b)(2), and (b)(3) of this Section, have completed a health questionnaire, have proof of negative results of a tuberculosis test completed within 12 months prior to the first day of providing care, submit criminal records check forms as required in 10A NCAC 09 .2702, and annual in-service training as described in Rule .1705(b)(5) of this Section. While the individual provides care at a family child care home, copies of required information shall be on file in the home available for review by the Division.

(c) An individual who provides care for less than five hours in a week, during planned absences of the operator shall meet all requirements listed in Paragraph (b) of this Rule, except the requirements for annual in-service training and a high school diploma or GED. The individual shall be literate.

(d) The operator shall review the appropriate requirements found in this Chapter, including the Emergency Preparedness and Response Plan, and in G.S. Chapter 110, Article 7 with any individuals who are providing care prior to the individual's assuming responsibility for the children. The operator and individual providing care shall sign and date a statement which attests that this review was completed. This statement shall be kept on file in the home available for review by the Division.

(e) An individual who provides care during unplanned absences of the operator, such as medical emergencies, shall be at least 18 years old and submit criminal records check forms as required in 10A NCAC 09 .2702, Paragraph (j). The children of an emergency caregiver shall not be counted in the licensed capacity for the first day of the emergency caregiver's service.

(f) The provisions of G.S. 110-90.2 which exclude persons with certain criminal records or personal habits or behavior which may be harmful to children from operating or being employed in a family child care home are hereby incorporated by reference and shall also apply to any person on the premises with the operator's permission when the children are present. This exclusion shall not apply to parents or other persons who enter the home only for the purpose of performing parental responsibilities; nor does it include persons who enter the home for brief periods for the purpose of conducting business with the operator and who are not left alone with the children.

(g) The parent of a child enrolled in any family child care home subject to regulation under G.S. 110, Article 7 shall be allowed unlimited access to the home during its operating hours for the purposes of contacting the child or evaluating the home and the care provided by the operator. The parent shall notify the operator of his or her presence immediately upon entering the premises.

(h) An operator licensed to care for children overnight may sleep during the nighttime hours when all the children are asleep, provided:

(1) the operator and the children in care, excluding the operator's own children, are on ground level;

(2) the operator can hear and respond quickly to the children if needed; and

(3) a battery operated smoke detector or an electrically operated (with a battery backup) smoke detector is located in each room where children are sleeping.

(i) Each operator shall develop and adopt a written plan of care for completing routine tasks (including running errands, meeting family and personal demands, and attending classes) to ensure that routine tasks shall not interfere with the care of children during hours of operation. The plan shall:

(1) specify typical times for completing routine tasks and include those times on the written schedule, or specify that routine tasks will not occur during hours of operation;

(2) specify the names of any individuals, such as additional caregivers or substitutes, who will be responsible for the care of children when the operator is attending to routine tasks;

(3) specify how the operator shall maintain compliance with transportation requirements specified in 10A NCAC 09 .1723 if children are transported;

(4) specify how parents will be notified when children accompany the operator off premises for routine tasks not specified on the written schedule;

(5) specify any other steps the operator shall take to ensure routine tasks will not interfere with the care of children; and

(6) be given and explained to parents of children in care on or before the first day the child attends the home. Parents shall sign a statement acknowledging the receipt and explanation of the plan. Parents shall also give written permission for their child to be transported by the operator for specific routine tasks that are included on the written schedule. The acknowledgment and written parental permission shall be retained in the child's record as long as the child is enrolled at the home and a copy of each document shall be maintained on file for review by the Division.

(j) If the operator amends the written plan, the operator shall give written notice of the amendment to parents of all enrolled children at least 30 days before the amended plan is implemented. Each parent shall sign a statement acknowledging the receipt and explanation of the amendment. The operator shall retain the acknowledgement in the child's records as long as the child is enrolled in the home and a copy shall be maintained on file for review by the Division.

History Note: Authority G.S. 110-85; 110-86(3); 110-88(1); 110-91; 110-99; 110-105; 143B-168.3;
Eff. January 1, 1986;
Amended Eff. July 1, 2015; May 1, 2013; November 1, 2006; April 1, 2003; April 1, 1999; July 1, 1998; January 1, 1991; January 1, 1990; July 1, 1988; January 1, 1987.

10A NCAC 09 .1705 HEALTH AND TRAINING REQUIREMENTS FOR FAMILY CHILD CARE HOME OPERATORS

(a) Prior to receiving a license, each family child care home operator shall:

(1) Complete and keep on file a health questionnaire which attests to the operator's physical and emotional ability to care for children. The Division may require a written statement or medical examination report signed by a licensed physician or other authorized health professional if there is reason to believe that the operator's health may adversely affect the care of the children based upon observations and complaints made to the Division.

(2) Obtain written proof that he or she is free of active tuberculosis. The results indicating the individual is free of active tuberculosis shall be obtained within 12 months prior to applying for a license.

(3) Complete within 12 months prior to applying for a license a basic first aid course that shall address principles for responding to emergencies, and techniques for handling common childhood injuries, accidents and illnesses such as choking, burns, fractures, bites and stings, wounds, scrapes, bruises, cuts and lacerations, poisoning, seizures, bleeding, allergic reactions, eye and nose injuries and sudden changes in body temperature.

(4) Successfully complete within 12 months prior to applying for a license a course by the American Heart Association or the American Red Cross or other organizations approved by the Division in cardiopulmonary resuscitation (CPR) appropriate for the ages of children in care. Other organizations shall be approved if the Division determines that the courses offered are substantially equivalent to those offered by the American Red Cross. Successfully completed is defined as demonstrating competency, as evaluated by the instructor, in performing CPR. Documentation of successful completion of the course from the American Heart Association, the American Red Cross, or other organization approved by the Division shall be on file in the home.

(b) After receiving a license, an operator shall:

(1) Update the health questionnaire referenced in Paragraph (a) of this Rule annually. The Division may require the operator to obtain written proof that he or she is free of active tuberculosis.

(2) Complete a first aid course as referenced in Paragraph (a) of this Rule. First aid training shall be renewed on or before expiration of the certification or every three years, whichever is less.

(3) Successfully complete a CPR course as referenced in Paragraph (a) of this Rule. CPR training shall be renewed on or before the expiration of the certification, or every two years, whichever is less.

(4) If licensed to care for infants ages 12 months and younger, complete ITS-SIDS training within four months of receiving the license, and complete it again every three years from the completion of previous ITS-SIDS training. Completion of ITS-SIDS training may be included once every three years in the number of hours needed to meet the annual in-service training requirement in Paragraph (b)(5) of this Rule.

(5) Complete 12 clock hours of annual in-service training in the topic areas required by G.S. 110-91(11), except that persons with at least 10 years work experience as a caregiver in a child care arrangement regulated by the Division of Child Development and Early Education shall complete eight clock hours of annual in-service training. Only training which has been approved by the Division as referenced in Rule .0708 of this Chapter shall count toward the required hours of annual in-service training. The operator shall maintain a record of annual in-service training activities in which he or she has participated. The record shall include the subject matter, the topic area in G.S. 110-91(11) covered, the name of the training provider or organization, the date training was provided and the number of hours of training completed. First aid training may be counted no more than once every three years.

(6) Within one year of the effective date of the license, complete the Emergency Preparedness and Response in Child Care training. For the purposes of this Rule, the Emergency Preparedness and Response in Child Care is a training approved by the Division on creating an Emergency Preparedness and Response Plan and practicing, responding to, and recovering from emergencies in child care facilities. Existing operators have two years as of the effective date of this Rule to complete the Emergency Preparedness and Response in Child Care training. Documentation of completion of the training shall be maintained in the operator's personnel file.

(7) Upon completion of the Emergency Preparedness and Response in Child Care training, develop the Emergency Preparedness and Response Plan. The Emergency Preparedness and Response Plan means a written plan that addresses how a child care facility will respond to both natural and man-made disasters, such as fire, tornado, flood, power failures, chemical spills, bomb threats, earthquakes, blizzards, nuclear disaster, or a dangerous person in the vicinity, to ensure the safety and protection of the children and additional caregivers. This Plan must be on a template provided by the Division available at https://rmp.nc.gov/portal/#, completed within four months of completion of the Emergency Preparedness and Response in Child Care training, and available for review. The Plan shall include the following:

(A) written procedures for accounting for all in attendance, including the location of the children, staff, volunteer and visitor attendance lists and the name of the person(s) responsible for bringing the lists in the event of an emergency;

(B) a description for how and when children shall be transported;

(C) methods for communicating with parents and emergency personnel or law enforcement;

(D) a description of how children's nutritional and health needs will be met;

(E) the relocation and reunification process;

(F) emergency telephone numbers;

(G) evacuation diagrams showing how the operator, family members, children and any other individuals who may be present will evacuate during an emergency;

(H) the date of the last revision of the plan;

(I) specific considerations for non-mobile children and children with special needs; and

(J) the location of the Ready to Go File. A Ready to Go File means a collection of information on children, additional caregivers and the facility, to utilize, if an evacuation occurs. The file shall include, but is not limited to, a copy of the Emergency Preparedness and Response Plan, contact information for individuals to pick-up children, each child's Application for Child Care, medication authorizations and instructions, any action plans for children with special health care needs, a list of any known food allergies of children and additional caregiver, additional caregiver contact information, Incident Report forms, an area map, and emergency telephone numbers.

(8) Review the Emergency Preparedness and Response Plan annually or when information in the plan changes, to ensure all information is current.

(9) Review the Family Child Care Home's Emergency Preparedness and Response Plan with additional caregivers during orientation and on an annual basis.

History Note: Authority G.S. 110-85; 110-88; 110-91; 143B-168.3;
Eff. January 1, 1986;
Amended Eff. July 1, 2015; July 1, 2008; May 1, 2004; July 1, 1998; November 1, 1989; January 1, 1987.

10A NCAC 09 .1720 SAFETY, MEDICATION, AND SANITATION REQUIREMENTS

(a) To assure the safety of children in care, the operator shall:

(1) empty firearms of ammunition and keep both in separate, locked storage;

(2) keep items used for starting fires, such as matches and lighters, out of the children's reach;

(3) keep all medicines in locked storage;

(4) keep hazardous cleaning supplies and other items that might be poisonous, e.g., toxic plants, out of reach or in locked storage when children are in care;

(5) keep first aid supplies in a place accessible to the operator;

(6) keep tobacco products out of reach or in locked storage when children are in care;

(7) ensure the equipment and toys are in good repair and are developmentally appropriate for the children in care;

(8) have a working telephone within the family child care home. Telephone numbers for the fire department, law enforcement office, emergency medical service, and poison control center shall be posted near the telephone;

(9) have access to a means of transportation that is always available for emergency situations;

(10) be able to recognize common symptoms of illnesses;

(11) conduct a monthly fire drill; and

(12) conduct a "shelter in place drill" or "lockdown drill" as defined in 10A NCAC 09 .0102 at least every three months.

(b) The operator may provide care for a mildly ill child who has a Fahrenheit temperature of less than 100 degrees axillary or 101

degrees orally and who remains capable of participating in routine group activities; provided the child does not:

(1) have the sudden onset of diarrhea characterized by an increased number of bowel movements compared to the child's normal pattern and with increased stool water;
(2) have two or more episodes of vomiting within a 12 hour period;
(3) have a red eye with white or yellow eye discharge until 24 hours after treatment;
(4) have scabies or lice;
(5) have known chicken pox or a rash suggestive of chicken pox;
(6) have tuberculosis, until a health professional states that the child is not infectious;
(7) have strep throat, until 24 hours after treatment has started;
(8) have pertussis, until five days after appropriate antibiotic treatment;
(9) have hepatitis A virus infection, until one week after onset of illness or jaundice;
(10) have impetigo, until 24 hours after treatment; or
(11) have a physician's or other health professional's written order that the child be separated from other children.

(c) The following provisions apply to the administration of medication in family child care homes:

(1) No prescription or over-the-counter medication and no topical, non-medical ointment, repellent, lotion, cream or powder shall be administered to any child:
  (A) without written authorization from the child's parent;
  (B) without written instructions from the child's parent, physician or other health professional;
  (C) in any manner not authorized by the child's parent, physician or other health professional;
  (D) after its expiration date; or
  (E) for non-medical reasons, such as to induce sleep.
(2) Prescribed medications:
  (A) shall be stored in the original containers in which they were dispensed with the pharmacy labels specifying:
    (i) the child's name;
    (ii) the name of the medication or the prescription number;
    (iii) the amount and frequency of dosage;
    (iv) the name of the prescribing physician or other health professional; and
    (v) the date the prescription was filled; or
  (B) if pharmaceutical samples, shall be stored in the manufacturer's original packaging, shall be labeled with the child's name, and shall be accompanied by written instructions specifying:
    (i) the child's name;
    (ii) the names of the medication;
    (iii) the amount and frequency of dosage;
    (iv) the signature of the prescribing physician or other health professional; and
    (v) the date the instructions were signed by the physician or other health professional; and
  (C) shall be administered only to the child for whom they were prescribed.
(3) A parent's written authorization for the administration of a prescription medication described in Paragraph (c)(2) of this Rule shall be valid for the length of time the medication is prescribed to be taken.
(4) Over-the-counter medications, such as cough syrup, decongestant, acetaminophen, ibuprofen, topical antibiotic cream for abrasions, or medication for intestinal disorders shall be stored in the manufacturer's original packaging on which the child's name is written or labeled and shall be accompanied by written instructions specifying:
  (A) the child's name;
  (B) the names of the authorized over-the-counter medication;
  (C) the amount and frequency of the dosages;
  (D) the signature of the parent, physician or other health professional; and
  (E) the date the instructions were signed by the parent, physician or other health professional. The permission to administer over-the-counter medications is valid for up to 30 days at a time, except as allowed in Subparagraphs (c)(6), (7), (8), and (9) of this Rule. Over-the-counter medications shall not be administered on an "as needed" basis, other than as allowed in Subparagraphs (c)(6), (7), (8), and (9) of this Rule.
(5) When questions arise concerning whether any medication should be administered to a child, the caregiver may decline to administer the medication without signed, written dosage instructions from a licensed physician or authorized health professional.
(6) A parent may give a caregiver standing authorization for up to six months to administer

prescription or over-the-counter medication to a child, when needed, for chronic medical conditions and for allergic reactions. The authorization shall be in writing and shall contain:

(A) the child's name;
(B) the subject medical conditions or allergic reactions;
(C) the names of the authorized over-the-counter medications;
(D) the criteria for the administration of the medication;
(E) the amount and frequency of the dosages;
(F) the manner in which the medication shall be administered;
(G) the signature of the parent;
(H) the date the authorization was signed by the parent; and
(I) the length of time the authorization is valid, if less than six months.

(7) A parent may give a caregiver standing authorization for up to 12 months to apply over-the-counter, topical ointments, topical teething ointment or gel, insect repellents, lotions, creams, and powders --- such as sunscreen, diapering creams, baby lotion, and baby powder --- to a child, when needed. The authorization shall be in writing and shall contain:

(A) the child's name;
(B) the names of the authorized ointments, repellents, lotions, creams, and powders;
(C) the criteria for the administration of the ointments, repellents, lotions, creams, and powders;
(D) the manner in which the ointments, repellents, lotions, creams, and powders shall be applied;
(E) the signature of the parent;
(F) the date the authorization was signed by the parent; and
(G) the length of time the authorization is valid, if less than 12 months.

(8) A parent may give a caregiver standing authorization to administer a single weight-appropriate dose of acetaminophen to a child in the event the child has a fever and a parent cannot be reached. The authorization shall be in writing and shall contain:

(A) the child's name;
(B) the signature of the parent;
(C) the date the authorization was signed by the parent;
(D) the date that the authorization ends or a statement that the authorization is valid until withdrawn by the parent in writing.

(9) A parent may give a caregiver standing authorization to administer an over-the-counter medication as directed by the North Carolina State Health Director or designee, when there is a public health emergency as identified by the North Carolina State Health Director or designee. The authorization shall be in writing, may be valid for as long as the child is enrolled, and shall contain:

(A) the child's name;
(B) the signature of the parent;
(C) the date the authorization was signed by the parent; and
(D) the date that the authorization ends or a statement that the authorization is valid until withdrawn by the parent in writing.

(10) Pursuant to G.S. 110-102.1A, a caregiver may administer medication to a child without parental authorization in the event of an emergency medical condition when the child's parent is unavailable, providing the medication is administered with the authorization and in accordance with instructions from a health care professional as defined in Rule .0102(16) of this Chapter.

(11) A parent may withdraw his or her written authorization for the administration of medications at any time in writing.

(12) Any medication remaining after the course of treatment is completed or after authorization is withdrawn shall be returned to the child's parents. Any medication the parent fails to retrieve within 72 hours of completion of treatment, or withdrawal of authorization, shall be discarded.

(13) Any time prescription or over-the-counter medication is administered by a caregiver to children receiving care, including any time medication is administered in the event of an emergency medical condition without parental authorization as permitted by G.S. 110-102.1A, the child's name, the date, time, amount and type of medication given, and the name and signature of the person administering the medication shall be recorded. This information shall be noted on a medication permission slip, or on a separate form developed by the provider which includes the required information. This information shall be available for review by the Division during the time period the medication is being administered and for at least six months after the medication is administered. No documentation shall be required when items listed in Subparagraph (c)(7) of this Rule are applied to children.

(d) To assure the health of children through proper sanitation, the operator shall:

(1) collect and submit samples of water from each well used for the children's water supply for bacteriological analysis to the local health department or a laboratory certified to analyze drinking water for public water supplies by the North Carolina Division of Laboratory Services every two years. Results of the analysis shall be on file in the home;

(2) have sanitary toilet, diaper changing and hand washing facilities. Diaper changing areas shall be separate from food preparation areas;

(3) use sanitary diapering procedures. Diapers shall be changed whenever they become soiled or wet. The operator shall:

(A) wash his or her hands before, as well as after, diapering each child;

(B) ensure the child's hands are washed after diapering the child; and

(C) place soiled diapers in a covered, leak proof container which is emptied and cleaned daily;

(4) use sanitary procedures when preparing and serving food. The operator shall:

(A) wash his or her hands before and after handling food and feeding the children; and

(B) ensure the child's hands are washed before and after the child is fed;

(5) wash his or her hands, and ensure the child's hands are washed, after toileting or handling bodily fluids.

(6) refrigerate all perishable food and beverages. The refrigerator shall be in good repair and maintain a temperature of 45 degrees Fahrenheit or below. A refrigerator thermometer is required to monitor the temperature;

(7) date and label all bottles for each individual child, except when there is only one bottle fed child in care;

(8) have a house that is free of rodents;

(9) screen all windows and doors used for ventilation;

(10) have all household pets vaccinated with up-to-date vaccinations as required by North Carolina law and local ordinances. Rabies vaccinations are required for cats and dogs; and

(11) store garbage in waterproof containers with tight fitting covers.

(e) The operator shall not force children to use the toilet and the operator shall consider the developmental readiness of each individual child during toilet training.

(f) The operator shall not use tobacco products at any time while children are in care. Smoking or use of tobacco products shall not be permitted indoors while children are in care, or in a vehicle when children are transported.

History Note: Authority G.S. 110-88; 110-91(6); Eff. July 1, 1998; Amended Eff. July 1, 2015; May 1, 2004; April 1, 2003; April 1, 2001.

10A NCAC 09 .1721 REQUIREMENTS FOR RECORDS

(a) The operator shall maintain the following health records for each enrolled child, including his or her own preschool child(ren):

(1) a copy of the child's health assessment as required by G.S. 110-91(1);

(2) a copy of the child's immunization record;

(3) a health and emergency information form provided by the Division that is completed and signed by a child's parent. A copy of the form can be found on the Division's website at http://ncchildcare.nc.gov/pdf_forms/DCD-0377.pdf. The completed form shall be on file the first day the child attends. An operator may use another form other than the one provided by the Division, as long as the form includes the following information:

(A) the child's name, address, and date of birth;

(B) the names of individuals to whom the child may be released;

(C) the general status of the child's health;

(D) any allergies or restrictions on the child's participation in activities with instructions from the child's parent or physician;

(E) the names and phone numbers of persons to be contacted in an emergency situation;

(F) the name and phone number of the child's physician and preferred hospital;

(G) authorization for the operator to seek emergency medical care in the parent's absence; and

(4) when medication is administered, authorization for the operator to administer the specific medication according to the parent's or physician's instructions.

(b) The operator shall complete and maintain other records which include:

(1) documentation of the operator's Emergency Preparedness and Response Plan on a template which is provided by the Division at http://rmp.nc.gov/portal/#;

(2) documentation that monthly fire drills are practiced. The documentation shall include the date each drill is held, the time of day, the length of time taken to evacuate the home, and the operator's signature;

(3) incident reports that are completed each time a child receives medical treatment by a physician, nurse, physician's assistant, nurse practitioner, community clinic, or local health department,

as a result of an incident occurring while the child is in the family child care home. Each incident shall be reported on a form provided by the Division, signed by the operator and the parent, and maintained in the child's file. A copy of the form can be found on the Division's website at http://ncchildcare.nc.gov/pdf_forms/DCDEE-0058.pdf. A copy shall be mailed to the Division within seven calendar days after the incident occurs;

(4) an incident log which is filled out any time an incident report is completed. This log shall be cumulative and maintained in a separate file and shall be available for review by the Division. This log shall be completed on a form supplied by the Division. A copy of the form can be found on the Division's website at http://ncchildcare.nc.gov/pdf_forms/incident_log_i.pdf;

(5) documentation that a monthly check for hazards on the outdoor play area is completed. This form shall be supplied by the Division and shall be maintained in the family child care home for review by the Division. A copy of the form can be found of the Division's website at http://ncchildcare.nc.gov/pdf_forms/fcch_outdoor_inspection_checklist.pdf;

(6) Accurate daily attendance records for all children in care, including the operator's own preschool children. The attendance record shall indicate the date and time of arrival and departure for each child; and

(7) documentation of lockdown or shelter-in-place drills giving the date each drill is held, the time of day, the length of time taken to get into designated locations and the signature of the person who conducted the drill.

(c) Written records shall be maintained as follows:

(1) All children's records as required in this Chapter, except medication permission slips as required in Rule .1720(c)(13) of this Section, must be kept on file one year from the date the child is no longer enrolled.

(2) Additional caregiver records as required in this Chapter shall be maintained on file one year from the employee's last date of employment.

(3) Current program records as required in this Chapter shall be maintained on file for as long as the license remains valid. Prior versions shall be maintained based on the time frame in the following charts:

(A) A minimum of 30 days from the revision or replacement date:

Record	Rule
Daily Schedule	.1718(7)
Infant Feeding Schedule	.1706(f)
SIDS Sleep Chart/Visual Check	.1724(8)

(B) A minimum of one year from the revision or replacement date:

Record	Rule
Attendance	.1721(b)(6)
Emergency Numbers	.1720(a)(8)
Emergency Preparedness and Response Plan	.1721(b)(1)
Field Trip/Transportation Permission	.1723(1)
Fire Drill Log	.1721(b)(2)
Lockdown or Shelter-in-Place Drill Log	.1721(b)(7)
Incident Log	.1721(b)(4)
Playground Inspection	.1721(b)(5)
Pet Vaccinations	.1720(d)(10)

(4) Well-water analysis, pool inspection and inspections for local ordinances as referenced in Rules .1720(d)(1), .1719(7), and .1702(d) of this Section shall remain on file at the family child care home for as long as the license remains valid.

(5) Records may be maintained in a paper format or electronically, except that records that require a signature of a staff person or parent shall be maintained in a paper format.

(6) All records required in this Chapter shall be available for review by the Division.

History Note: Authority G.S. 110-85; 110-88; 110-91(1),(9); Eff. July 1, 1998;
Amended Eff. July 1, 2015; July 1, 2010; July 1, 2008; April 1, 2003; April 1, 2001.

10A NCAC 09 .2318 RETENTION OF FORMS AND REPORTS BY A CHILD CARE OPERATOR

Each child care center operator must retain records as follows:

(1) All children's records as required in this Chapter, except the Medication Permission Slip as referenced in Rule .0803(13) of this Chapter, shall be maintained on file for at least one year from the date the child is no longer enrolled in the center.

(2) All personnel records as required in this Chapter shall be maintained on file for at least one year from the date the employee is no longer employed.

(3) Current program records shall be maintained on file for as long as the license remains valid. Prior versions shall be maintained based on the time frame in the following charts:

(a) A minimum of 30 days from the revision or replacement date:

Record	Rule
Activity Plan	.0508(d)
Allergy Postings	.0901(f)
Feeding Schedule	.0902(a)
Menu	.0901(b)
SIDS Sleep Chart/Visual Check	.0606(a)(7)

(b) A minimum of one year from the revision or replacement date:

Record	Rule
Attendance	.0302(d)(3)
Daily Schedule	.0508(a)
Emergency Medical Care Plan	.0302(c)(3) and .0802(a)
Lockdown or Shelter-in-Place Drill Log	.0302(d)(8)
Emergency Preparedness and Response Plan	.0607(c);
Field Trip/Transportation Permission	.2507(a) and .0512(b)(3)
Fire Drill Log	.0302(d)(5)
Evacuation plan for non - mobile children in Centers not meeting institutional building code	.0604(p)
Incident Log	.0802(e)
Playground Inspection	.0605(n)
Safe Arrival and Departure Procedures	.1003(b)

(4) All building, fire, sanitation and pool inspections as referenced in G.S. 110-91, and Rules .0302 and .1403 of this Chapter shall remain on file at the center for as long as the license remains valid.

(5) Records may be maintained in a paper format or electronically, except that records that require a signature of a staff person or parent shall be maintained in a paper format.

(6) All records required in this Chapter shall be available for review by the Division.

History Note: Authority G.S. 110-85; 110-91(9); 143B-168.3; Eff. January 1, 1986;
Amended Eff. July 1, 2015; July 1, 2010; July 1, 2008.

10A NCAC 09 .2829 QUALITY POINT OPTIONS

Operators may earn one additional quality point toward a voluntary rated license as described in Rule .2802 of this Section as follows:

(1) Education options:

(a) Completing additional education coursework as follows:

(i) An Infant and Toddler Certificate, by 75 percent of infant and toddler teachers,

(ii) An A.A.S. or higher in early childhood education or child development by 75 percent of teachers,

(iii) A BA or BS or higher in early childhood education or child development by 75 percent of lead teachers,

(iv) An A.A.S. or higher in early childhood education or child development by all lead teachers,

(v) A North Carolina School Age Care Credential or have completed six semester hours in school-age coursework by 75 percent of group leaders, or

(vi) An Infant and Toddler Certificate or has a BA or BS or higher in early childhood education or child development by a family child care home provider;

(b) Completing 20 additional annual in-service training hours for full-time lead teachers and teachers, and staff working part-time completing additional hours based on the chart in Rule .0707(c) of this Chapter;

(c) Completing 20 annual in-service training hours for family child care home providers in addition to those required by Rule .1705(b)(5) of this Chapter;

(d) 75 percent of lead teachers and teachers having at least 10 years of documented and confirmed by the Division early childhood work experience;

(e) All lead teachers and teachers having at least five years of documented and confirmed by the Division of early childhood work experience employed by no more than two different employers;

(f) Having a combined turnover rate of 20 percent or less for the administrator, program coordinator, lead teachers, teachers and group leader positions over the last 12 months if the program has earned at least four points in education;

(g) In a stand alone school age program, 75 percent of group leaders having at

least five years verifiable school-age work experience employed in no more than two different school-age settings; or

(2) Programmatic options:

(a) Using a curriculum as defined in Rule .0102(7) of this Chapter. This programmatic option is not available to facilities that are required to use an approved curriculum in accordance with Rule .2802(d) of this Section;

(b) Having group sizes decreased by at least one child per age group from the seven point level as described in Rule .2818(c) of this Section;

(c) Having staff/child ratios decreased by at least one child per age group from the seven point level as described in Rule .2818(c) of this Section;

(d) Meeting at least two of the following three programs standards:

(i) Having enhanced policies which include the following topics: field trip policy, staff development plan, medication administration, enhanced discipline policy, and health rules for attendance;

(ii) Having a staff benefits package that offers at least four of the following six benefits: paid leave for professional development, paid planning time, vacation, sick time, retirement or health insurance; or

(iii) Having evidence of an infrastructure of parent involvement that includes at least two of the following: parent newsletters offered at least quarterly, parent advisory board, periodic conferences for all children, or parent information meetings offered at least quarterly;

(e) Completing a 30 hour or longer business training course by a family child care home provider;

(f) Completing a business training course and a wage and hour training by the center administrator that is at least 30 hours total;

(g) Restricting enrollment to four preschool children in a family child care home; or

(h) Reducing infant capacity by at least one child from the seven point level for a family child care home as described in Rule .2828(g)(3) of this Section.

History Note: Authority G.S. 110-85; 110-88(7); 110-90(4); 143B-168.3; S.L. 2011-145, s. 10.7(b);
Eff. May 1, 2006;
Amended Eff. December 1, 2006;
Recodified from Rule .2823 Eff. August 1, 2012;
Amended Eff. July 1, 2015; September 1, 2012.

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10A NCAC 73A .0101 SCOPE AND PURPOSE

Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996 prohibits the provision of Temporary Assistance for Needy Families assistance to individuals who have a drug related felony conviction occurring on or after August 22, 1996. The purpose of the rules in this Subchapter is to set forth requirements for the substance use screening and drug testing of Work First Program applicants and recipients.

History Note: Authority G.S. 108A-25.2; 108A-29.1; 143B-153;
Eff. June 1, 2015.

10A NCAC 73A .0102 DEFINITIONS

The following definitions apply to this Chapter:

(1) "Controlled substance" means as defined in G.S. 90-87(5).

(2) "Drug test" means the production and submission of a biochemical assay by an applicant or recipient for chemical analysis to detect illegal use of drugs. Such chemical analysis shall meet the requirements of the Controlled Substance Examination Regulation Act, G.S. 95, Article 20.

(3) "Illegal use of controlled substances" means the violation of State or federal law for use of the drugs set forth in Rule .0103 of this Section.

(4) "Reasonable suspicion" means a sufficient basis to believe that the applicant or recipient is engaged in the illegal use of a controlled substance and such reasonable suspicion shall be established only by one of the following:

(a) a score of three or above on the verbal screening questionnaire, the Drug Abuse Screening Test (DAST-10), or

(b) a criminal conviction relating to an illegal controlled substance within the past three years.

(5) "Substance use screening" means utilizing the DAST-10 to determine a potential for a substance use disorder.

(6) "Applicant or recipient" for the purposes of drug testing means as defined in G.S. 108A-29.1(a).

History Note: Authority G.S. 108A-29.1; 143B-153; Eff. June 1, 2015.

10A NCAC 73A .0103 DRUG TESTING

The county director shall require a basic five panel drug test for applicants and recipients of Work First Family Assistance where there is a reasonable suspicion the applicant or recipient is engaged in the illegal use of controlled substances. The drug test shall identify the illegal use of the following controlled substances:

(1) cannabinoids;
(2) cocaine;
(3) methamphetamines or amphetamines;
(4) opiates; and
(5) phencyclidine.

History Note: Authority G.S. 108A-29.1; 143B-153; Eff. June 1, 2015.

10A NCAC 73A .0104 DRUG TESTING REQUIREMENTS

(a) The Drug Abuse Screening Test (DAST-10) shall be completed by an applicant or recipient as a condition of eligibility for the Work First program.

(b) If the applicant or recipient refuses to complete the DAST-10, the applicant or recipient shall be ineligible for cash assistance.

(c) If reasonable suspicion of illegal use of controlled substances exists, the applicant or recipient shall submit to a drug test at the Division of Social Services' expense with the Division of Social Services' contracted vendor, as required by G.S. 108A-29.1.

(d) If an applicant or recipient declines to submit to the drug test or fails to complete the drug test, the applicant or recipient shall be ineligible for cash assistance.

(e) If an applicant or recipient substitutes, adulterates, or tampers with the drug testing, the applicant or recipient shall be ineligible for cash assistance.

History Note: Authority G.S. 108A-29.1; 143B-153; Eff. June 1, 2015.

10A NCAC 73A .0105 TECHNIQUES AND METHODS

(a) The analysis of drug test specimens shall be conducted by a laboratory licensed by the NC Department of Health and Human Services and certified by the Substance Abuse and Mental Health Services Administration (SAMHSA). Licensed and certified laboratories are listed in the Federal Register, which is incorporated by reference, including subsequent amendments and editions and at http://www.samhsa.gov/workplace/lab-list, which is incorporated by reference, including subsequent amendments and editions.

(b) Controlled substances or metabolites of a controlled substance shall be tested and analyzed using approved analytical techniques or methods, as follows:

(1) immunoassay;
(2) thin-layer chromatography;
(3) gas chromatography;
(4) mass spectroscopy;
(5) high performance liquid chromatography; or
(6) spectroscopy.

(c) Results of the drug test analysis shall be expressed as equivalent to nanograms by weight of a controlled substance or metabolite, or a controlled substance per milliliter.

(d) The drug test threshold values shall meet the cutoff levels contained in the Mandatory Guidelines for Federal Workplace Drug Testing Programs as adopted by SAMHSA and identified in the chart below:

Initial Test Analyte	Initial Test Cutoff Concentration	Confirmatory Test Analyte	Confirmatory Test Cutoff Concentration
Marijuana Metabolites	50 ng/mL	THCA1	15 ng/mL
Cocaine Metabolites	150 ng/mL	Benzoylecgonine	100 ng/mL
Amphetamines AMP/MAMP	500 ng/mL	Amphetamine Methamphetamine	250 ng/mL 250 ng/mL
Opiate Metabolites Codeine/Morphine	2000 ng/mL	Codeine Morphine	2000 ng/mL 2000 ng/mL
Phencyclidine	25 ng/mL	Phencyclidine	25 ng/mL

History Note: Authority G.S. 108A-29.1; 143B-153; Eff. June 1, 2015.

10A NCAC 73A .0106 CONFIDENTIALITY

(a) A drug test given under this Section shall be confidential and consistent with the HIPAA Privacy Rule appearing in 45 CFR Parts 160, et seq., which is incorporated by reference, including subsequent amendments and editions, and State Law.

(b) The drug test results, medical history, or medications taken by the applicant or recipient shall be a confidential record unless its disclosure is otherwise authorized by law or by written consent from the applicant or recipient.

(c) The county departments of social services shall implement administrative, physical, and technical safeguards to maintain confidentiality of drug test results.

History Note: Authority G.S. 108A-29.1; 143B-153; Eff. June 1, 2015.

TITLE 12 – DEPARTMENT OF JUSTICE

12 NCAC 06A .0603 FIREARMS

All students shall maintain custody and security of firearms and ammunition while on NC Justice Academy property.

History Note: Authority G.S. 17D-2(c)(4); Eff. February 1, 1976; Readopted Eff. January 5, 1978; Amended Eff. June 1, 2015; August 1, 2009.

TITLE 15A – DEPARTMENT OF ENVIRONMENT AND NATURAL RESOURCES

15A NCAC 02N .0304 IMPLEMENTATION SCHEDULE FOR PERFORMANCE STANDARDS FOR NEW UST SYSTEMS AND UPGRADING REQUIREMENTS FOR EXISTING UST SYSTEMS LOCATED IN AREAS DEFINED IN RULE .0301(D)

(a) The following implementation schedule shall apply only to owners and operators of UST systems located within areas defined in Rule .0301(d) of this Section. This implementation schedule shall be used by the Department for tank owners and operators to comply with the secondary containment requirements contained in Rule .0301(d) for new UST systems and the secondary containment requirements contained in Rule .0302(a) for existing UST systems.

(1) All new UST systems and replacements to an UST system shall be provided with secondary containment as of April 1, 2001.

(2) All steel or metal connected piping and ancillary equipment of an UST, regardless of date of installation, shall be provided with secondary containment as of January 1, 2005.

(3) All fiberglass or non-metal connected piping and ancillary equipment of an UST, regardless of date of installation, shall be provided with secondary containment as of January 1, 2008.

(4) All UST systems installed on or before January 1, 1991 shall be provided with secondary containment as of January 1, 2008.

(5) All USTs installed after January 1, 1991, and prior to April 1, 2001, shall be provided with secondary containment as of January 1, 2020. Owners of USTs located within 100 to 500 feet of a public water supply well, if the well serves only a single facility and is not a community water system may seek a variance in accordance with Paragraphs (d) through (i) of this Rule.

(b) All owners and operators of UST systems shall implement the following enhanced leak detection monitoring as of April 1, 2001. The enhanced leak detection monitoring shall consist of the following:

(1) Installation of an automatic tank gauging system for each UST;

(2) Installation of an electronic line leak detector for each pressurized piping system;

(3) Conducting one 0.1 gallon per hour (gph) test per month or one 0.2 gph test per week on each UST system;

(4) Conducting a line tightness test capable of detecting a leak rate of 0.1 gph, once per year for each suction piping system. No release detection is required for suction piping that is designed and constructed in accordance with 40 CFR 280.41(b)(2)(i) through (v);

(5) If the UST system is located within 500 feet of a public water supply well or within 100 feet of any other well supplying water for human consumption, sample the supply well at least once per year. The sample collected from the well shall be characterized in accordance with:

(A) Standard Method 6200B, Volatile Organic Compounds Purge and Trap Capillary-Column Gas Chromatographic/Mass Spectrometric Method, which is incorporated by reference, including subsequent amendments, and may be obtained at http://www.standardmethods.org/ at a cost of sixty-nine dollars ($69.00);

(B) EPA Method 625, Base/Neutrals and Acids, which is incorporated by reference, including subsequent amendments, and may be accessed free of charge at http://water.epa.gov/scitech/methods/cwa/organics/upload/2007_07_10_methods_method_ organics_625.pdf; and

(C) If a waste oil UST system is present that does not meet the requirements for secondary containment in accordance with 40 CFR 280.42(b)(1) through (4), the sample shall also be analyzed for lead and chromium using Method 6010C, Inductively Coupled Plasma-Atomic Emission Spectrometry, which is incorporated by reference including subsequent amendments, and may be accessed free of charge at http://www.epa.gov/epawaste/hazard/testmethods/sw846/pdfs/6010c.pdf or Method 6020A, Inductively Coupled Plasma-Mass Spectrometry, which is incorporated by reference including

subsequent amendments, and may be accessed free of charge at http://www.epa.gov/epawaste/hazard/testmethods/sw846/pdfs/6020a.pdf; and

(6) The first sample collected in accordance with Subparagraph (b)(5) of this Rule shall be collected and the results received by the Division by October 1, 2000 and yearly thereafter.

(c) An UST system or UST system component installation completed on or after November 1, 2007 to upgrade or replace an UST system or UST system component described in Paragraph (a) of this Rule shall meet the performance standards of Section .0900 of this Subchapter.

(d) The Environmental Management Commission may grant a variance from the secondary containment upgrade requirements in Subparagraph (a)(5) of this Rule for USTs located within 100 to 500 feet of a public water supply well, if the well serves only a single facility and is not a community water system. Any request for a variance shall be in writing by the owner of the UST for which the variance is sought. The request for variance shall be submitted to the Director, Division of Waste Management, 1646 Mail Service Center, Raleigh, NC 27699-1646. The Environmental Management Commission shall grant the variance if the Environmental Management Commission finds facts to support the following conclusions:

(1) The variance will not endanger human health and welfare or groundwater; and

(2) UST systems are operated and maintained in compliance with all applicable federal laws and regulations and state laws and rules.

(e) The Environmental Management Commission may require the variance applicant to submit such information as the Environmental Management Commission deems necessary to make a decision to grant or deny the variance. Information that may be requested includes the following:

(1) Water supply well location, depth, construction specifications, and sampling results;

(2) Groundwater depth and flow direction; and

(3) Leak detection monitoring and testing results.

(f) The Environmental Management Commission may impose such conditions on a variance as the Environmental Management Commission deems necessary to protect human health and welfare and groundwater. Conditions for a variance may include the following:

(1) Increased frequency of leak detection and leak prevention monitoring and testing;

(2) Periodic water supply well sampling; and

(3) Increased reporting and recordkeeping.

(g) The findings of fact supporting any variance under this Rule shall be in writing and made part of the variance.

(h) The Environmental Management Commission may rescind a variance that was previously granted if the Environmental Management Commission discovers through inspection or reporting that the conditions of the variance are not met or that the facts no longer support the conclusions in Subparagraphs (d)(1) and (2) of this Rule.

(i) An owner of a UST system who is aggrieved by a decision of the Environmental Management Commission to deny or rescind a variance, may commence a contested case by filing a petition under G.S. 150B-23 within 60 days after receipt of the decision.

History Note: Authority G.S. 143-215.3(a)(15); 143B-282(a)(2)(h);
Temporary Adoption Eff. May 1, 2000;
Eff. April 1, 2001;
Amended Eff. June 1, 2015; November 1, 2007.

15A NCAC 02N .0903 TANKS

(a) Tanks must be protected from external corrosion in accordance with 40 CFR 280.20(a)(1), (2), (3), or (5).

(b) Owners and operators of tanks installed in accordance with 40 CFR 280.20(a)(2) shall comply with all applicable requirements for corrosion protection systems contained in this Subchapter.

(c) The exterior surface of a tank shall bear a permanent marking, code stamp, or label showing the following information:

(1) The engineering standard used;

(2) The diameter in feet;

(3) The capacity in gallons;

(4) The materials of construction of the inner and outer walls of the tank, including any external or internal coatings;

(5) Serial number or other unique identification number designated by the tank manufacturer;

(6) Date manufactured; and

(7) Identity of manufacturer.

(d) Tanks that will be reused shall be certified by the tank manufacturer prior to re-installation and meet all of the requirements of this Section. Tank owners and operators shall submit proof of certification to the Division along with a notice of intent (Rule .0902).

(e) Tanks shall be tested before and after installation in accordance with the following requirements:

(1) Pre- Installation Test - Before installation, the primary containment and the interstitial space shall be tested in accordance with the manufacturers written guidelines and PEI/RP100, "Recommended Practice for Installation of Underground Liquid Storage Systems." PEI/RP100, "Recommended Practice for Installation of Underground Liquid Storage Systems" is hereby incorporated by reference including subsequent amendments and editions. A copy may be obtained from Petroleum Equipment Institute, P.O. Box 2380, Tulsa, Oklahoma 74101-2380 at a cost of ninety-five dollars ($95.00). The presence of soap bubbles or water droplets during a pressure test, any change in vacuum beyond the limits specified by the tank manufacturer during a vacuum test, or any change in liquid level in an interstitial space liquid reservoir beyond the limits specified by the tank manufacturer, shall

be considered a failure of the integrity of the tank.

(2) Post-installation Test – The interstitial space shall be checked for a loss of pressure or vacuum, or a change in liquid level in an interstitial space liquid reservoir. Any loss of pressure or vacuum beyond the limits specified by the tank manufacturer, or a change in liquid level beyond the limits specified by the tank manufacturer, shall be considered a failure of the integrity of the tank.

(3) If a tank fails a pre-installation or post-installation test, tank installation shall be suspended until the tank is replaced or repaired in accordance with the manufacturer's specifications. Following any repair, the tank shall be re-tested in accordance with Subparagraph (e)(1) of this Rule if it failed the pre-installation test and in accordance with Subparagraph (e)(2) of this Rule if it failed the post-installation test.

(f) The interstitial spaces of tanks that are not monitored using vacuum, pressure, or hydrostatic methods shall be tested for tightness before UST system start-up, between six months and the first anniversary of start-up, and every three years thereafter. The interstitial space shall be tested using an interstitial tank tightness test method that is capable of detecting a 0.10 gallon per hour leak rate with a probability of detection (Pd) of at least 95 percent and a probability of false alarm (Pfa) of no more than 5 percent. The test method shall be evaluated by an independent testing laboratory, consulting firm, not-for-profit research organization, or educational institution using the most recent version of the United States Environmental Protection Agency's (EPA's) "Standard Test Procedures for Evaluating Leak Detection Methods." EPA's "Standard Test Procedures for Evaluating Leak Detection Methods" is hereby incorporated by reference including subsequent amendments and additions. A copy may be obtained by visiting EPA's Office of Underground Storage Tank website: http://www.epa.gov/OUST/pubs/protocol.htm and may be accessed free of charge. The independent testing laboratory, consulting firm, not-for-profit research organization, or educational institution shall certify that the test method can detect a 0.10 gallon per hour leak rate with a Pd of at least 95 percent and a Pfa of no more than 5 percent for the specific tank model being tested. If a tank fails an interstitial tank tightness test, it shall be replaced by the owner or operator or repaired by the manufacturer or the manufacturer's authorized representative in accordance with manufacturer's specifications. Tank owners and operators shall report all failed interstitial tank tightness tests to the Division within 24 hours. Failed interstitial tank tightness tests shall be reported by fax to the Division of Waste Management, Underground Storage Tank Section, at (919) 715-1117. Following any repair, the tank interstitial space shall be re-tested for tightness. The most recent interstitial tightness test record shall be maintained at the UST site or the tank owner's or operator's place of business and shall be available for inspection.

History Note: Authority G.S. 143-215.3(a)(15); 143B-282(a)(2)(h);
Eff. November 1, 2007;
Amended Eff. June 1, 2015; February 1, 2010.

15A NCAC 02N .0904 PIPING

(a) Piping, with the exception of flexible connectors and piping connections, shall be pre-fabricated with double-walled construction. Any flexible connectors or piping connections that do not have double-walled construction shall be installed in containment sumps that meet the requirements of 15A NCAC 02N .0905.

(b) Piping shall be constructed of non-corroding materials. Metal flexible connectors and piping connections shall be installed in containment sumps that meet the requirements of 15A NCAC 02N .0905.

(c) Piping shall comply with the UL 971 standard "Nonmetallic Underground Piping for Flammable Liquids;" that is in effect at the time the piping is installed. UL 971 standard "Nonmetallic Underground Piping for Flammable Liquids" is hereby incorporated by reference including subsequent amendments and editions. A copy may be obtained from Underwriters Laboratories, 333 Pfingsten Road, Northbrook, Illinois 60062-2096 at a cost of four hundred and two dollars ($402.00).

(d) Piping that is buried underground shall be constructed with a device or method that allows it to be located once it is installed.

(e) Piping that conveys regulated substances under pressure shall also be equipped with an automatic line leak detector that meets the requirements of 40 CFR 280.44(a).

(f) At the time of installation, the primary containment and interstitial space of the piping shall be initially tested, monitored during construction, and finally tested in accordance with the manufacturers written guidelines and PEI/RP100, "Recommended Practice for Installation of Underground Liquid Storage Systems." The presence of soap bubbles or water droplets or any loss of pressure beyond the limits specified by the piping manufacturer during testing shall be considered a failure of the integrity of the piping. If the piping fails a tightness test, it shall be replaced by the owner or operator or repaired by the manufacturer or the manufacturer's authorized representative in accordance with the manufacturer's written specifications. Following any repair, the piping shall be re-tested for tightness in accordance with the manufacturers written guidelines and PEI/RP100, "Recommended Practice for Installation of Underground Liquid Storage Systems."

(g) Piping that is not monitored continuously for releases using vacuum, pressure, or hydrostatic methods, shall be tested for tightness every three years following installation. The primary containment and interstitial space of the piping shall be tested in accordance with the manufacturers written guidelines and PEI/RP100 "Recommended Practice for Installation of Underground Liquid Storage Systems." If the piping fails a tightness test, it shall be replaced or repaired by the manufacturer or the manufacturer's authorized representative in accordance with the manufacturer's specifications. Following any repair, the piping shall be re-tested for tightness. The most recent periodic tightness test record shall be maintained at the UST site or the tank

owner or operator's place of business and shall be available for inspection.

History Note: Authority G.S. 143-215.3(a)(15); 143B-282(a)(2)(h);
Eff. November 1, 2007;
Amended Eff. June 1, 2015.

TITLE 21 – OCCUPATIONAL LICENSING BOARDS AND COMMISSIONS

CHAPTER 10 – BOARD OF CHIROPRACTIC EXAMINERS

21 NCAC 10 .0205 RENEWAL OF LICENSE

(a) General. The renewal, cancellation, and restoration of a license are governed by G.S. 90-155.

(b) License Renewal Form. On or about December 1st each year, the Board shall mail to each licentiate, at the licentiate's current office address on file, an individualized license renewal form for the ensuing year. A secure electronic version of the form shall also be available at www.ncchiroboard.com. A licentiate desiring license renewal shall note on the form any changes in name, address, specialty, employment circumstances, and history of criminal convictions. The licentiate shall also note continuing education obtained as set forth in Paragraph (c) of this Rule. The licentiate shall submit the completed form and the renewal fee prescribed in Paragraph (d) of this Rule to the Board before the deadline imposed by G.S. 90-155.

(c) Continuing Education. The license renewal form issued by the Board shall recite the cumulative hours of continuing education reported to the Board and credited to the individual licentiate for the current year. If the licentiate wishes to receive credit for continuing education obtained but not reported to the Board, the licentiate shall note on the license renewal form the name, date, sponsor, and duration of any unreported educational session. The Board shall not award credit for the session until the sponsor confirms the licentiate's attendance or participation. The licentiate shall also note on the license renewal form any professional development continuing education for which the licentiate seeks credit pursuant to 21 NCAC 10 .0210(d). As used in G.S. 90-155, one "day" of continuing education shall be defined as nine hours. Any licentiate seeking a hardship waiver of the continuing education requirement shall make. written application to the Board explaining the nature and circumstances of the hardship. Upon the applicant's showing that timely compliance with the continuing education requirement poses an undue hardship, the Board, in its discretion, may waive the requirement in whole or part or grant an extension of time within which to comply. "Undue hardship" includes protracted medical illness, natural disaster, or extended absence from the United States.

(d) Renewal Fee. A renewal fee in the maximum amount allowed by G.S. 90-155 shall be paid by each licentiate applying for renewal.

(e) Restoration of Cancelled License: Evidence of Proficiency. In order to provide evidence of proficiency, any former licentiate whose license has been cancelled due to non-compliance with G.S. 90-155 shall be re-examined and shall pay the application fee prescribed in 21 NCAC 10 .0202(d) to cover the cost of re-examination. Payment of the application fee shall not constitute payment of the statutory reinstatement fee.

(f) Military Hardship. A licentiate who is serving in the armed forces of the United States and to whom G.S. 93B-15(a) grants an extension of time to pay a renewal fee shall also be granted an identical extension of time to complete the continuing education required for license renewal.

History Note: Authority G.S. 90-142; 90-155; 93B-15;
Eff. February 1, 1976;
Readopted Eff. January 27, 1978;
Amended Eff. January 1, 1983; October 17, 1980;
Legislative Objection Lodged Eff. January 31, 1983;
Curative Amended Eff. February 18, 1983;
Amended Eff. June 1, 2015; July 1, 2011; January 4, 1993; December 1, 1988.

21 NCAC 10 .0210 INDIVIDUAL-STUDY CONTINUING EDUCATION

(a) Hours permitted. A doctor of chiropractic may obtain as many as eight credit hours of continuing education each year by successfully completing one or more individual-study courses approved by the Board.

(b) Course approval. The criteria for Board approval of any individual-study course are as follows:

(1) no practice-building or motivational courses shall be approved;

(2) no course shall be approved that requires participants, in order to utilize the information presented, to purchase equipment or clinical supplies available only through the course's instructors, sponsors, or co-sponsors;

(3) each subject taught shall fall within the extent and limitation of chiropractic licensure in this State as provided in G.S. 90-151;

(4) the subject matter shall be presented in a manner comparable to instruction at chiropractic colleges accredited by the Council on Chiropractic Education;

(5) the sponsor shall have a method for recording and verifying a doctor's participation expressed in credit hours and fractions thereof, and the sponsor shall assume responsibility for submitting a certificate of participation to the Board within 60 days after a doctor completes the course;

(6) the course shall include one or more examinations or other means of verifying that a participating doctor has mastered the material presented in the course.

(c) Sponsor's obligation. The sponsor shall provide such information as the Board deems necessary to evaluate the course according to the criteria set forth in Paragraph (b) of this Rule, including the syllabus, a curriculum vitae for each instructor, the method for verifying attendance, and the length of the course. Failure to provide information required by the Board shall be a

basis for denying the course. The application process for obtaining course approval is set forth in Rule .0207 of this Section.

(d) Professional development continuing education. A doctor of chiropractic may obtain continuing education credit for undertaking the professional development activities described in this Paragraph. Credit shall be awarded based on the actual time spent and shall not exceed two hours annually for all activities combined. To apply for credit, the doctor shall report such activities on his or her annual license renewal form as provided in Rule .0205(c) of this Section. Approved professional development activities shall include:

(1) reading scientific, peer-reviewed professional journals; or

(2) visiting vendor displays at professional association conventions to become familiar with trends in treatment technologies and new products.

(e) Attendance at interstate regulatory meetings. A doctor of chiropractic may obtain as many as 12 hours of continuing education credit annually by attending morning and afternoon sessions of a national meeting of the Federation of Chiropractic Licensing Boards or morning and afternoon sessions of a meeting of the National Board of Chiropractic Examiners.

History Note: Authority G.S. 90-142; 90-151; 90-155;
Eff. July 1, 2004;
Amended Eff. June 1, 2015.

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CHAPTER 17 – BOARD OF DIETETICS/NUTRITION

21 NCAC 17 .0119 DECLARATORY RULINGS

(a) A request for a declaratory ruling made pursuant to G.S. 150B-4 shall be in writing and addressed to the Board at the address provided in Rule .0104(c) of this Section. The request shall contain the following information:

(1) the name and address of the person requesting the ruling;

(2) the statute, rule, or order to which the request relates;

(3) a concise statement as to whether the request is for a ruling on the validity of a rule or on the applicability of a statute, rule, or order to a given factual situation; and

(4) a statement as to whether a hearing is desired, and if desired, the reason therefore.

(b) The Board shall refuse to issue a declaratory ruling under the following circumstances:

(1) when the Board determines it has already made a controlling decision on substantially similar facts in a contested case.

(2) when the facts underlying the request for a ruling on a rule were specifically considered at the time of the adoption of the rule in question; or

(3) when the subject matter of the request is involved in pending litigation to which the Board is a party.

History Note: Authority G.S. 90-356(2); 150B-4;
Eff. June 1, 2015.

21 NCAC 17 .0120 PETITIONS FOR ADOPTION, AMENDMENT, OR REPEAL OF RULES

(a) Rule-making petitions made pursuant to G.S. 150B-20 shall be sent to the Board. No special form is required, but the petitioner shall state his or her name and address. The petition shall include:

(1) the text of the proposed rule(s) for adoption or amendment;

(2) a statement of the reasons for the proposal;

(3) a statement of the effect of the proposal on existing rules or decisions;

(4) any data supporting the proposed rule change;

(5) if known, practices likely to be affected by the proposed rule change; and

(6) if known, persons likely to be affected by the proposed rule change.

(b) The Board shall make a decision to grant or deny the petition based upon a study of the facts stated in the petition, whether the public interest will be better served by granting or denying the petition, and any other relevant information, as determined by the Board.

History Note: Authority G.S. 90-356(2); 150B-20;
Eff. June 1, 2015.

21 NCAC 17 .0121 RULE MAKING NOTICE

Persons or agencies desiring to receive notice of the Board's rule making shall file a written request with the Board at the address provided in Rule .0104 (c) of this Section, furnishing their name, mailing address, and electronic mailing address, if applicable.

History Note: Authority G.S. 90-356(2); 150B-21.2(d);
Eff. June 1, 2015.

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CHAPTER 60 - BOARD OF REFRIGERATION EXAMINERS

21 NCAC 60 .0102 OFFICE OF BOARD

(a) The Board's office and mailing address is located at 889 US 70 Highway West, Garner, North Carolina 27529.

(b) The Board's website is http://www.refrigerationboard.org.

History Note: Authority G.S. 87-54;
Eff. February 1, 1976;
Readopted Eff. April 17, 1978;
Amended Eff. June 1, 2015; April 1, 2015; September 1, 2011; August 1, 2004; July 1, 2000; August 1, 1995; December 1, 1993; October 1, 1994.

This Section contains information for the meeting of the Rules Review Commission May 21 and July 16, 2015 at 1711 New Hope Church Road, RRC Commission Room, Raleigh, NC. Anyone wishing to submit written comment on any rule before the Commission should submit those comments to the RRC staff, the agency, and the individual Commissioners. Specific instructions and addresses may be obtained from the Rules Review Commission at 919-431-3000. Anyone wishing to address the Commission should notify the RRC staff and the agency no later than 5:00 p.m. of the 2nd business day before the meeting. Please refer to RRC rules codified in 26 NCAC 05.

RULES REVIEW COMMISSION MEMBERS

Appointed by Senate	**Appointed by House**
Jeff Hyde (1st Vice Chair)	Garth Dunklin (Chair)
Margaret Currin	Stephanie Simpson (2nd Vice Chair)
Jay Hemphill	Anna Baird Choi
Faylene Whitaker	Jeanette Doran
	Ralph A. Walker

COMMISSION COUNSEL

Abigail Hammond	(919)431-3076
Amber Cronk May	(919)431-3074
Amanda Reeder	(919)431-3079

RULES REVIEW COMMISSION MEETING DATES

July 16, 2015	August 20, 2015
September 17, 2015	October 15, 2015

RULES REVIEW COMMISSION MEETING
MINUTES
May 21, 2015

The Rules Review Commission met on Thursday, May 21, 2015, in the Commission Room at 1711 New Hope Church Road, Raleigh, North Carolina. Commissioners present were: Anna Choi, Margaret Currin, Jeanette Doran, Garth Dunklin, Jeff Hyde, Stephanie Simpson, Ralph Walker, and Faylene Whitaker.

Staff members present were Commission Counsels Abigail Hammond, Amber Cronk May, and Amanda Reeder; and Julie Brincefield, Kelly Bailey, Alex Burgos, and Dana Vojtko.

The meeting was called to order at 10:04 a.m. with Chairman Dunklin presiding.

Chairman Dunklin introduced OAH Extern Phillip Thomas.

Chairman Dunklin read the notice required by G.S. 138A-15(e) and reminded the Commission members that they have a duty to avoid conflicts of interest and the appearances of conflicts.

APPROVAL OF MINUTES

Chairman Dunklin asked for any discussion, comments, or corrections concerning the minutes of the April 16, 2015 meeting. There were none and the minutes were approved as distributed.

FOLLOW UP MATTERS

Child Care Commission

10A NCAC 09 .0302, .0604, .0607, .0707, .1701, .1705, .1720, .1721, .2318, and .2829 - All rewritten rules were unanimously approved.

Acupuncture Licensing Board

21 NCAC 01 .0108, .0109, .0110, .0111, .0601, .0602, .0603, .0604, .0605, .0606, .0607, .0608, and .0609 - All rules were withdrawn at the request of the agency pursuant to 26 NCAC 05 .0107. No action was required by the Commission.

Irrigation Contractors Licensing Board
21 NCAC 23 .0105 - The review of this Rule will occur at the June meeting**.** No action was required by the Commission.

Board of Physical Therapy Examiners
21 NCAC 48C .0104 - This Rule has been returned at the request of the agency pursuant to 150B-21.12(d). No action was required by the Commission.

Building Code Council
2012 NC Residential Code, Sections R101.2, R202, and R324; 2012 Building Code, Chapter 36; and 2012 Fire Code, 4504.1. - The review of these rules will occur at a later meeting. No action was required by the Commission.

LOG OF FILINGS (PERMANENT RULES)
Social Services Commission
All rules were unanimously approved with the following exceptions:
The Commission objected to Rule 10A NCAC 73A .0107, finding that the language in Paragraph (b) relating to drug testing is unclear and ambiguous. The Rule references a twelve day period that is not set by statute. The remainder of the sentence provides no guidance to the "individual who fail[ed] the drug test" as to what type of documentation is considered or to whom the documentation needs to be provided for review. Line 8 uses the term "may" to indicate that the allowance of additional time is permissive, but provides no guidance to as to how a determination is reached regarding the allowance of additional time.

The Commission objected to Rule 10A NCAC 73A .0108, finding that the language in Paragraph (c) does not provide reporting requirements and that the terms "successful completion" and "satisfactory participation" are unclear and ambiguous. The second sentence of Paragraph (c) provides no guidance to the qualified professional in substance abuse as to how to timely report completion of or participation in the substance abuse treatment program. There is no guidance as to what qualifies as timely and there is no direction on how to provide the treatment information.

Carlotta Dixon from the agency addressed the Commission.

Sharon D. Moore from the agency addressed the Commission.

Justice Academy
12 NCAC 06A .0603 was unanimously approved.

Environmental Management Commission
All rules were unanimously approved.

Board of Chiropractic Examiners
All rules were unanimously approved.

Board of Dental Examiners
The Commission extended the period of review on all rules. In accordance with G.S. 150B-21.10 and G.S. 150B-21.13, the Commission extended the period of review to allow the Board of Dental Examiners additional time to revise the rules in response to technical change requests.

Board of Dietetics/Nutrition
All rules were unanimously approved.

Board of Refrigeration Examiners
21 NCAC 60 .0102 was unanimously approved.

Prior to the review of the rules from the Board of Refrigeration Examiners, Commissioner Choi recused herself and did not participate in any discussion or vote concerning the rules because her law firm assists the board with rulemaking.

Building Code Council
All rules were unanimously approved.

EXISTING RULES REVIEW
Historical Commission
07 NCAC 04 - The Commission unanimously approved the report as submitted by the agency.

Water Pollution Systems Operators Certification Commission
15A NCAC 08 – The Commission unanimously approved the report as submitted by the agency.

Water Treatment Facility Operators Certification Board
15A NCAC 18D - The Commission unanimously approved the report as submitted by the agency.

Department of Revenue
17 NCAC 03 - The Commission unanimously approved the report as submitted by the agency.
17 NCAC 06 – The Commission unanimously approved the report as submitted by the agency.

Medical Care Commission
10A NCAC 13D – As reflected in the attached letter, the Commission voted for readoption of these rules pursuant to G.S. 150B-21.3A(c)(2) no later than November 30, 2016.

COMMISSION BUSINESS
Staff gave the Commission a brief legislative update.

At 10:46 a.m., Chairman Dunklin ended the public meeting of the Rules Review Commission and called the meeting into closed session pursuant to G.S. 143-318.11(a)(3) to discuss the lawsuit filed by the State Board of Education against the Rules Review Commission.

The Commission came out of closed session and reconvened at 11:54 a.m.

The meeting adjourned at 11:55 a.m.

The next regularly scheduled meeting of the Commission is Tuesday, June 16th at 10:00 a.m.

There is a digital recording of the entire meeting available from the Office of Administrative Hearings /Rules Division.

Respectfully Submitted,

_____
Alexander Burgos, Paralegal

Minutes approved by the Rules Review Commission:

_____
Garth Dunklin, Chair

May 2015

Rules Review Commission
Meeting
Please **Print** Legibly

Name	Agency
BARRY GUPTON	NCDOI - NCBCC
Mark Strickland	NCDOJ - NC Justice Academy
Marion Williams	NCDOJ - NC Justice Academy
Janice Davidson	NC Dept of Revenue
Rhonda R. Smith	NC Dept of Revenue
Lenny Marcucci	NC Dept of Revenue
Ray Rapp	NC DOR
Charla Burrill	NCBDN
Ruth Strauss	NC DENR
Jay Frick	NC DENR
STEVE REID	NC DENR
Debra Allen	NC DHHS
Laura Hewitt	DCDEE "
Kris Horton	DHHS
Shawn Maier	NC DOT
Cindria Merritt	NCDENR
Mekella Anthony	DHHS
Johnice Tabron	DHHS-OJJ
Sharon D Hart	"
LINDA RAYNOR	NC DENR
Dana Tillip	NC Justice Acad.

May 2015

Rules Review Commission
Meeting
Please **Print** Legibly

Name	Agency
Matt Sawchak	Ellis & Winters LLP
FRANCES McDONALD	NC Lic Bd for General Contractors
Carlotta Dixon	NCDHHS DSS
Josh Davis	DCR
Kevin Cherry	DCR
Kevin Howell	DCR

STATE OF NORTH CAROLINA
OFFICE OF ADMINISTRATIVE HEARINGS

Mailing address:
6714 Mail Service Center
Raleigh, NC 27699-6714

Street address:
1711 New Hope Church Rd
Raleigh, NC 27609-6285

May 21, 2015

Nadine Pfeiffer, Rulemaking Coordinator
N.C. Medical Care Commission
2701 Mail Service Center
Raleigh, NC 27699-2701

Re: Readoption pursuant to G.S. 150B-21.3A(c)(2)g of **10A NCAC 13D**

Dear Ms. Pfeiffer:

Attached to this letter are the rules subject to readoption pursuant to the periodic review and expiration of existing rules as set forth in G.S. 150B-21.3A(c)(2)g. After consultation with your agency, this set of rules was discussed at the February 19, 2015 Rules Review Commission meeting regarding the scheduling of these rules for readoption. **Pursuant to G.S. 150B-21.3A(d)(2), the rules identified on the attached printout shall be readopted by the agency no later than November 30, 2016.**

If you have any questions regarding the Commission's action, please let me know.

Sincerely,

Abigail M. Hammond

Abigail M. Hammond
Commission Counsel

Enclosure

Administration 919/431-3000 fax:919/431-3100
Rules Division 919/431-3000 fax: 919/431-3104
Judges and Assistants 919/431-3000 fax: 919/431-3100
Clerk's Office 919/431-3000 fax: 919/431-3100
Rules Review Commission 919/431-3000 fax: 919/431-3104
Civil Rights Division 919/431-3036 fax: 919/431-3103

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RRC DETERMINATION
PERIODIC RULE REVIEW
July 01, 2014 through June 30, 2015

Medical Care Commission
Total: 6

RRC Determination: Necessary with substantive public interest

Rule	Determination	APO Review Date
10A NCAC 13D .2001	Necessary with substantive public interest	March 22, 2015
10A NCAC 13D .2210	Necessary with substantive public interest	March 22, 2015
10A NCAC 13D .2303	Necessary with substantive public interest	March 22, 2015
10A NCAC 13D .2402	Necessary with substantive public interest	March 22, 2015
10A NCAC 13D .2503	Necessary with substantive public interest	March 22, 2015
10A NCAC 13D .3201	Necessary with substantive public interest	March 22, 2015

LIST OF APPROVED PERMANENT RULES
May 21, 2015 Meeting

CHILD CARE COMMISSION

Application for a License for a Child Care Center	10A NCAC 09 .0302
General Safety Requirements	10A NCAC 09 .0604
Emergency Preparedness and Response	10A NCAC 09 .0607
In-Service Training Requirements	10A NCAC 09 .0707
General Provisions Related to Licensure of Homes	10A NCAC 09 .1701
Health and Training Requirements for Family Child Care Ho...	10A NCAC 09 .1705
Safety, Medication, and Sanitation Requirements	10A NCAC 09 .1720
Requirements for Records	10A NCAC 09 .1721
Retention of Forms and Reports by a Child Care Operator	10A NCAC 09 .2318
Quality Points Options	10A NCAC 09 .2829

SOCIAL SERVICES COMMISSION

Scope and Purpose	10A NCAC 73A .0101
Definitions	10A NCAC 73A .0102
Drug Testing	10A NCAC 73A .0103
Drug Testing Requirements	10A NCAC 73A .0104
Techniques and Methods	10A NCAC 73A .0105
Confidentiality	10A NCAC 73A .0106

JUSTICE ACADEMY

Firearms	12 NCAC 06A .0603

ENVIRONMENTAL MANAGEMENT COMMISSION

Implementation Schedule for Performance Standards for New...	15A NCAC 02N .0304
Tanks	15A NCAC 02N .0903
Piping	15A NCAC 02N .0904

CHIROPRACTIC EXAMINERS, BOARD OF

Renewal of License	21 NCAC 10 .0205
Individual-Study Continuing Education	21 NCAC 10 .0210

DIETETICS/NUTRITION, BOARD OF

Declaratory Rulings	21 NCAC 17 .0119
Petitions for Adoption, Amendment or Repeal of Rules	21 NCAC 17 .0120
Rule Making Notice	21 NCAC 17 .0121

REFRIGERATION EXAMINERS, BOARD OF

Office of the Board	21 NCAC 60 .0102

BUILDING CODE COUNCIL	
2012 NC Residential Code/Width	R311.7.1
2012 NC Plumbing Code/Heel- or side-inlet quarter bends	706.4
2012 NC Plumbing Code/Liquid-type, Trowel-applied, Load-b...	417.5.2.6
2012 NC Fire Code/Solar Photovoltaic Power Systems	605.11
2012 NC Fire Code/Hookah or Water Pipe Use	310.9
2012 NC Energy Conservation Code/Air Exchange Rate	Table 405.5.2(1)
2011 NC Electrical Code/Special Occupancies	230.2 (B)

RRC DETERMINATION
PERIODIC RULE REVIEW
May 21, 2015
Necessary with Substantive Public Interest

Cultural Resources, Department of
07 NCAC 04R .0203
07 NCAC 04R .0204
07 NCAC 04R .0205
07 NCAC 04R .0206
07 NCAC 04R .0304
07 NCAC 04R .0702
07 NCAC 04R .0703
07 NCAC 04R .0704
07 NCAC 04R .0705
07 NCAC 04R .0706
07 NCAC 04R .0707
07 NCAC 04R .0708
07 NCAC 04R .0709
07 NCAC 04R .0710
07 NCAC 04R .0711
07 NCAC 04R .0712
07 NCAC 04R .0713
07 NCAC 04R .0714
07 NCAC 04R .0715
07 NCAC 04R .0716
07 NCAC 04R .0717
07 NCAC 04R .0718
07 NCAC 04R .0801
07 NCAC 04R .0802
07 NCAC 04R .0803
07 NCAC 04R .0804
07 NCAC 04R .0805
07 NCAC 04R .0806
07 NCAC 04R .0807
07 NCAC 04R .0808
07 NCAC 04R .1002
07 NCAC 04R .1003
07 NCAC 04R .1004
07 NCAC 04R .1005
07 NCAC 04R .1006
07 NCAC 04R .1007
07 NCAC 04R .1008
07 NCAC 04R .1009
07 NCAC 04R .1010
07 NCAC 04R .1011
07 NCAC 04R .1012
07 NCAC 04R .1013

Water Pollution Control System Operator Certification Commission
15A NCAC 08F .0203
15A NCAC 08F .0401
15A NCAC 08F .0405
15A NCAC 08F .0406
15A NCAC 08F .0407
15A NCAC 08F .0501
15A NCAC 08F .0502
15A NCAC 08F .0503
15A NCAC 08F .0504
15A NCAC 08F .0505
15A NCAC 08F .0506
15A NCAC 08G .0102
15A NCAC 08G .0201
15A NCAC 08G .0204
15A NCAC 08G .0301
15A NCAC 08G .0302
15A NCAC 08G .0304
15A NCAC 08G .0306
15A NCAC 08G .0307
15A NCAC 08G .0505
15A NCAC 08G .0701
15A NCAC 08G .0801
15A NCAC 08G .0803

Water Treatment Facility Operators Certification Board
15A NCAC 18D .0105
15A NCAC 18D .0201
15A NCAC 18D .0203
15A NCAC 18D .0205
15A NCAC 18D .0206
15A NCAC 18D .0307
15A NCAC 18D .0308
15A NCAC 18D .0309
15A NCAC 18D .0701

Revenue, Department of
17 NCAC 06B .0104
17 NCAC 06B .0106
17 NCAC 06B .0107
17 NCAC 06B .0109
17 NCAC 06B .0112
17 NCAC 06B .0113
17 NCAC 06B .0114
17 NCAC 06B .0115
17 NCAC 06B .0116
17 NCAC 06B .3203
17 NCAC 06B .3204
17 NCAC 06B .3407
17 NCAC 06B .3501
17 NCAC 06B .3503
17 NCAC 06B .3513
17 NCAC 06B .3529
17 NCAC 06B .3718
17 NCAC 06B .3723
17 NCAC 06B .3804
17 NCAC 06B .3904
17 NCAC 06B .3905
17 NCAC 06B .4003
17 NCAC 06B .4005
17 NCAC 06B .4101
17 NCAC 06B .4102
17 NCAC 06B .4103
17 NCAC 06C .0110
17 NCAC 06C .0117
17 NCAC 06C .0123
17 NCAC 06C .0124
17 NCAC 06C .0126
17 NCAC 06C .0203
17 NCAC 06C .0204

17 NCAC 06D .0102

RRC DETERMINATION
PERIODIC RULE REVIEW
May 21, 2015
Necessary without Substantive Public Interest

Cultural Resources, Department of
07 NCAC 04L .0101
07 NCAC 04L .0102

Historical Commission
07 NCAC 04M .0104
07 NCAC 04M .0105
07 NCAC 04M .0106
07 NCAC 04M .0201
07 NCAC 04M .0202
07 NCAC 04M .0203
07 NCAC 04M .0204
07 NCAC 04M .0301
07 NCAC 04M .0401
07 NCAC 04M .0402
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07 NCAC 04M .0508
07 NCAC 04M .0509
07 NCAC 04M .0510
07 NCAC 04M .0511
07 NCAC 04M .0512

Cultural Resources, Department of
07 NCAC 04N .0101
07 NCAC 04N .0102
07 NCAC 04N .0103
07 NCAC 04N .0104
07 NCAC 04N .0105
07 NCAC 04N .0106
07 NCAC 04N .0107
07 NCAC 04N .0108
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07 NCAC 04P .0114
07 NCAC 04P .0115
07 NCAC 04P .0116
07 NCAC 04Q .0101
07 NCAC 04Q .0102
07 NCAC 04Q .0104
07 NCAC 04Q .0105
07 NCAC 04Q .0106
07 NCAC 04Q .0107
07 NCAC 04Q .0201
07 NCAC 04R .0101
07 NCAC 04R .0201
07 NCAC 04R .0202
07 NCAC 04R .0301
07 NCAC 04R .0302
07 NCAC 04R .0303
07 NCAC 04R .0305
07 NCAC 04R .0501
07 NCAC 04R .0502
07 NCAC 04R .0503
07 NCAC 04R .0504
07 NCAC 04R .0601
07 NCAC 04R .0602
07 NCAC 04R .0603
07 NCAC 04R .0604
07 NCAC 04R .0605
07 NCAC 04R .0606
07 NCAC 04R .0901
07 NCAC 04R .0902
07 NCAC 04R .0903
07 NCAC 04R .0904
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07 NCAC 04R .1501
07 NCAC 04R .1502
07 NCAC 04R .1503
07 NCAC 04S .0101
07 NCAC 04S .0102
07 NCAC 04S .0103
07 NCAC 04S .0104
07 NCAC 04S .0105
07 NCAC 04S .0106
07 NCAC 04S .0107
07 NCAC 04S .0108
07 NCAC 04S .0109
07 NCAC 04S .0110
07 NCAC 04T .0101
07 NCAC 04T .0102
07 NCAC 04T .0103
07 NCAC 04T .0104
07 NCAC 04T .0105
07 NCAC 04T .0106
07 NCAC 04T .0107

Water Pollution Control System Operator Certification Commission
15A NCAC 08F .0101
15A NCAC 08F .0102
15A NCAC 08F .0201
15A NCAC 08F .0202
15A NCAC 08F .0301
15A NCAC 08F .0402
15A NCAC 08F .0403
15A NCAC 08F .0404
15A NCAC 08G .0101
15A NCAC 08G .0203
15A NCAC 08G .0205
15A NCAC 08G .0303
15A NCAC 08G .0305
15A NCAC 08G .0308
15A NCAC 08G .0401
15A NCAC 08G .0402
15A NCAC 08G .0403
15A NCAC 08G .0404

15A NCAC 08G .0405
15A NCAC 08G .0406
15A NCAC 08G .0407
15A NCAC 08G .0408
15A NCAC 08G .0409
15A NCAC 08G .0410
15A NCAC 08G .0501
15A NCAC 08G .0503
15A NCAC 08G .0504
15A NCAC 08G .0602
15A NCAC 08G .0603
15A NCAC 08G .0802
15A NCAC 08G .0804
15A NCAC 08G .0901
15A NCAC 08G .1001

Water Treatment Facility Operators Certification Board
15A NCAC 18D .0103
15A NCAC 18D .0202
15A NCAC 18D .0301
15A NCAC 18D .0303
15A NCAC 18D .0304
15A NCAC 18D .0401
15A NCAC 18D .0404
15A NCAC 18D .0501
15A NCAC 18D .0508
15A NCAC 18D .0601

Revenue, Department of
17 NCAC 06B .0102
17 NCAC 06B .0607
17 NCAC 06B .3206
17 NCAC 06B .3402
17 NCAC 06B .3404
17 NCAC 06B .3406
17 NCAC 06B .3521
17 NCAC 06B .3527
17 NCAC 06B .3528
17 NCAC 06B .3714
17 NCAC 06B .3716
17 NCAC 06B .3724
17 NCAC 06B .3901
17 NCAC 06B .3902
17 NCAC 06B .3903
17 NCAC 06B .4004
17 NCAC 06B .4006
17 NCAC 06C .0107
17 NCAC 06C .0108
17 NCAC 06C .0112
17 NCAC 06C .0119
17 NCAC 06C .0120
17 NCAC 06C .0201
17 NCAC 06D .0201
17 NCAC 06D .0207
17 NCAC 06D .0208
17 NCAC 06D .0209
17 NCAC 06D .0210

RRC DETERMINATION
PERIODIC RULE REVIEW
May 21, 2015
Unnecessary

Cultural Resources, Department of
07 NCAC 04O .0102
07 NCAC 04O .0103
07 NCAC 04O .0104
07 NCAC 04O .0105
07 NCAC 04O .0106
07 NCAC 04O .0107
07 NCAC 04O .0201
07 NCAC 04O .0202
07 NCAC 04O .0203
07 NCAC 04O .0204
07 NCAC 04O .0306
07 NCAC 04P .0101
07 NCAC 04Q .0103
07 NCAC 04Q .0202
07 NCAC 04Q .0203
07 NCAC 04U .0101
07 NCAC 04U .0102

Water Treatment Facility Operators Certification Board
15A NCAC 18D .0403

Revenue, Department of
17 NCAC 03C .0103
17 NCAC 03C .0104
17 NCAC 03C .0105
17 NCAC 03C .0108
17 NCAC 06B .0108
17 NCAC 06B .0117
17 NCAC 06B .0118
17 NCAC 06B .0606
17 NCAC 06B .0610
17 NCAC 06B .0613

AGENDA
RULES REVIEW COMMISSION
THURSDAY, JULY 16, 2015 10:00 A.M.
1711 New Hope Church Rd., Raleigh, NC 27609

I. Ethics reminder by the chair as set out in G.S. 138A-15(e)

II. Approval of the minutes from the last meeting

III. Follow-up matters
   A. Pesticide Board – 02 NCAC 09L .0504, .0505, .0507, .0522, .0529, .1102, .1103, .1104,.1108, .1109 (Reeder)

IV. Review of Log of Filings (Permanent Rules) for rules filed between May 21, 2015 and June 22, 2015
- Child Care Commission (May)
- Criminal Justice Education and Training Standards Commission (May)
- Board of Electrolysis Examiners (Reeder)

- Board of Massage and Bodywork Therapy (May)
- Board of Examiners for Nursing Home Administrators (Reeder)
- Board of Pharmacy (Reeder)
- Substance Abuse Professional Practice Board (Reeder)
- State Human Resources Commission (Reeder)

V. Existing Rules Review
- Review of Reports
  1. 02 NCAC 20B - Board of Agriculture
  2. 02 NCAC 37 - Board of Agriculture
  3. 02 NCAC 42 - Gasoline and Oil Inspection Board
  4. 02 NCAC 59A - Soil and Water Commission
  5. 02 NCAC 59B - Soil and Water Commission
  6. 02 NCAC 59C - Soil and Water Commission
  7. 02 NCAC 59E - Soil and Water Commission
  8. 02 NCAC 59F - Soil and Water Commission
  9. 02 NCAC 59G - Soil and Water Commission
  10. 02 NCAC 60A - Board of Agriculture
  11. 02 NCAC 60B - Board of Agriculture
  12. 15A NCAC 01I - Department of Environment and Natural Resources
  13. 15A NCAC 09 - Division of Forest Resources
  14. 21 NCAC 11- Board of Employee Assistance Professionals
  15. 21 NCAC 60 - Board of Refrigeration Examiners
  16. 21 NCAC 63 - Social Work Certification and Licensure Board

VI. Commission Business
- Legislative Update
- Next meeting: Thursday, August 20, 2015

Commission Review

Log of Permanent Rule Filings
May 21, 2015 through June 22, 2015

CHILD CARE COMMISSION

The rules in Chapter 9 are child care rules and include definitions (.0100); general provisions related to licensing (.0200); procedures for obtaining a license (.0300); issuance of provisional and temporary licenses (.0400); age and developmentally appropriate environments for centers (.0500); safety requirements for child care centers (.0600); health and other standards for center staff (.0700); health standards for children (.0800); nutrition standards (.0900); transportation standards (.1000); building code requirements for child care centers (.1300); space requirements (.1400); temporary care requirements (.1500); family child care home requirements (.1700); discipline (.1800); special procedures concerning abuse/neglect in child care (.1900); rulemaking and contested case procedures (.2000); religious-sponsored child care center requirements (.2100); administrative actions and civil penalties (.2200); forms (.2300); child care for mildly ill children (.2400); care for school-age children (.2500); child care for children who are medically fragile (.2600); criminal records checks (.2700); voluntary rated licenses (.2800); developmental day services (.2900); and NC pre-kindergarten services (.3000).

Emergency Preparedness and Response 10A NCAC 09 .0607
Amend/*

CRIMINAL JUSTICE EDUCATION AND TRAINING STANDARDS COMMISSION

The rules in Chapter 9 are from the Criminal Justice Education and Training Standards Commission. This Commission has primary responsibility for setting statewide education, training, employment, and retention standards for criminal justice personnel (not including sheriffs).

The rules in Subchapter 9B cover minimum standards for: employment (.0100); schools and training programs (.0200); criminal justice instructors (.0300); completion of training (.0400); school directors (.0500); and certification of post-secondary criminal justice education programs (.0600).

Specialized Driver Instructor Training Amend/*	12	NCAC	09B	.0227
Basic Training - Wildlife Enforcement Officers Repeal/*	12	NCAC	09B	.0228
Basic Training - Juvenile Court Counselors and Chief Court... Amend/*	12	NCAC	09B	.0235
Basic Training - Juvenile Justice Officers Amend/*	12	NCAC	09B	.0236
Terms and Conditions of Specialized Instructor Certification Amend/*	12	NCAC	09B	.0305
Time Requirement for Completion of Training Amend/*	12	NCAC	09B	.0401

The rules in Subchapter 9C concern the administration of criminal justice education and training standards including responsibilities of the criminal justice standards division (.0100); forms (.0200); certification of criminal justice officers (.0300); accreditation of criminal justice schools and training courses (.0400); minimum standards for accreditation of associate of applied science degree programs incorporating basic law enforcement training (.0500); and equipment and procedures (.0600).

Probationary Certification Amend/*	12	NCAC	09C	.0303

The rules in Subchapter 9E relate to the law enforcement officers' in-service training program.

Minimum Training Specifications: Annual In-Service Training Amend/*	12	NCAC	09E	.0105

ELECTROLYSIS EXAMINERS, BOARD OF

The rules in Chapter 19 are from the Board of Electrolysis Examiners and include general provisions (.0100); application procedures (.0200); administrative law procedures (.0300); sanitation, equipment and supplies (.0400); schools (.0600); and continuing education (.0700).

Fees Amend/*	21	NCAC	19	.0201
Application for Licensure Amend/*	21	NCAC	19	.0202
Application for Renewal, Reinstatement, or Reactivation o... Amend/*	21	NCAC	19	.0203
Application for Renewal, Reinstatement, or Reactivation o... Amend/*	21	NCAC	19	.0204
Cleaning, Sterilization, and Safety Precautions for Instr... Amend/*	21	NCAC	19	.0407
Client Evaluation Amend/*	21	NCAC	19	.0409

Supervising Physician Amend/*	21	NCAC	19	.0501
Application for and Renewal of School Certification Amend/*	21	NCAC	19	.0602
School Equipment Amend/*	21	NCAC	19	.0608
Certification of Schools in Other States or Jurisdictions Amend/*	21	NCAC	19	.0622
Continuing Education Requirements, License Renewal, Reins... Amend/*	21	NCAC	19	.0701
Board Approval of Courses Amend/*	21	NCAC	19	.0702

MASSAGE AND BODYWORK THERAPY, BOARD OF

The rules in Chapter 30 concern organization and general provisions (.0100); application for licensure (.0200); licensing (.0300); business practices (.0400); standards of professional conduct (.0500); massage and bodywork therapy schools (.0600); continuing education (.0700); rules (.0800); complaints, disciplinary action and hearings (.0900); and massage and bodywork therapy establishments (.1000).

Application and Scope Readopt/*	21	NCAC	30	.0201
Continuing Education Requirements Readopt/*	21	NCAC	30	.0701
Continuing Education Definitions Amend/*	21	NCAC	30	.0702
Definitions Adopt/*	21	NCAC	30	.1001
Licensure of Massage and Bodywork Therapy Establishments Adopt/*	21	NCAC	30	.1002
Requirements for Licensure Adopt/*	21	NCAC	30	.1003
Massage Establishment Operations Adopt/*	21	NCAC	30	.1004
Client Records Retention and Ownership Adopt/*	21	NCAC	30	.1005
Inspection Upon Application Adopt/*	21	NCAC	30	.1006
Periodic Inspections Adopt/*	21	NCAC	30	.1007
Transfer of Massage and Bodywork Therapy Establishment Li... Adopt/*	21	NCAC	30	.1008
Sexual Activity Prohibited Adopt/*	21	NCAC	30	.1009
Disciplinary Sanctions; Reporting Requirements Adopt/*	21	NCAC	30	.1010
Refusal to Issue, Suspension or Revocation of License Adopt/*	21	NCAC	30	.1011
Unlicensed Practice Adopt/*	21	NCAC	30	.1012
Fees Adopt/*	21	NCAC	30	.1013

Term of License 21 NCAC 30 .1014
Adopt/*

Background Investigation Required for Applicant 21 NCAC 30 .1015
Adopt/*

NURSING HOME ADMINISTRATORS, BOARD OF EXAMINERS FOR

The rules in Subchapter 37D concern new licenses including general provisions (.0100); application for license (.0200); education, experience, and required course (.0300); administrators in training (.0400); preceptors (.0500); national exam (.0600); and state exam (.0700).

Initial Licensure Fee 21 NCAC 37D .0202
Readopt/*

Required Course 21 NCAC 37D .0303
Readopt/*

Application to Become Administrator-In-Training 21 NCAC 37D .0402
Readopt/*

Administrator-In-Training Selection of Preceptor 21 NCAC 37D .0404
Readopt/*

National Exam Application 21 NCAC 37D .0602
Readopt/*

State Examination Administration 21 NCAC 37D .0703
Readopt/*

The rules in Subchapter 37E concern applications for reciprocity/endorsement.

Application Process 21 NCAC 37E .0101
Readopt/*

Application Contents 21 NCAC 37E .0102
Readopt/*

The rules in Subchapter 37Fconcern temporary license requirements.

Issuance of Temporary License 21 NCAC 37F .0102
Readopt/*

The rules in 37G concern renewal requirements (.0100); inactive licenses (.0200); reinstatement (.0300); and duplicate licenses (.0400).

Renewal Fee 21 NCAC 37G .0102
Readopt/*

Inactive Requirements 21 NCAC 37G .0201
Readopt/*

Duplicate License Requirements 21 NCAC 37G .0401
Readopt/*

The rules in Subchapter 37H concern continuing education requirements.

Continuing Education Programs of Study 21 NCAC 37H .0102
Readopt/*

PHARMACY, BOARD OF

The rules in Chapter 46 cover organization of the board (.1200); general definitions (.1300); hospitals and other health facilities (.1400); admission requirements and examinations (.1500); licenses and permits (.1600); drugs dispensed by nurse and physician assistants (.1700); prescriptions (.1800); forms (.1900); administrative provisions (.2000); elections (.2100); continuing education (.2200); prescription information and records (.2300); dispensing in health departments (.2400); miscellaneous provisions (.2500); devices (.2600); nuclear pharmacy (.2700); compounding (.2800); product selection (.2900); disposal of unwanted drugs (.3000); clinical pharmacist practitioner (.3100); impaired pharmacist peer review program (.3200); and registry of pharmacist technicians (.3300).

Right to Refuse a Prescription	21	NCAC	46	.1801
Amend/*				

SUBSTANCE ABUSE PROFESSIONAL PRACTICE BOARD

The rules in Chapter 68 include general provisions (.0100); certification (.0200); clinical addictions specialist (.0300); education (.0400); ethical principles of conduct (.0500); grounds for discipline and disciplinary procedures (.0600); and appeals process (.0700).

Definitions	21	NCAC	68	.0101
Amend/*				
Credentials by Endorsement or Reciprocity Based on Military...	21	NCAC	68	.0227
Adopt/*				
Substance Abuse Credential by Endorsement or Reciprocity ...	21	NCAC	68	.0228
Adopt/*				

STATE HUMAN RESOURCES COMMISSION

The rules in Subchapter 1H concern recruitment and selection including general provisions (.0600); general provision for priority consideration (.0700); promotional priority (.0800); reduction-in-force-priority reemployment (.0900); exempt priority consideration (.1000); and veteran's preference (.1100).

Exempt Priority Consideration-Policy and Scope	25	NCAC	01H	.1001
Amend/*				
Agency Responsibilities	25	NCAC	01H	.1003
Amend/*				
Office of State Personnel Responsibilities	25	NCAC	01H	.1004
Repeal/*				
Mandatory Right to a Position	25	NCAC	01H	.1005
Repeal/*				

This Section contains the full text of some of the more significant Administrative Law Judge decisions along with an index to all recent contested cases decisions which are filed under North Carolina's Administrative Procedure Act. Copies of the decisions listed in the index and not published are available upon request for a minimal charge by contacting the Office of Administrative Hearings, (919) 431-3000. Also, the Contested Case Decisions are available on the Internet at http://www.ncoah.com/hearings.

OFFICE OF ADMINISTRATIVE HEARINGS

Chief Administrative Law Judge
JULIAN MANN, III

Senior Administrative Law Judge
FRED G. MORRISON JR.

ADMINISTRATIVE LAW JUDGES

Melissa Owens Lassiter
Don Overby
J. Randall May
A. B. Elkins II
Selina Brooks
Phil Berger, Jr.
J. Randolph Ward

AGENCY	CASE NUMBER	DATE	PUBLISHED DECISION REGISTER CITATION
BOARD OF ARCHITECTURE			
Board of Architecture v. Anthony Hunt	14 BOA 04954	03/03/15	30:01 NCR 77
DEPARTMENT OF PUBLIC SAFETY			
Jack Norris v. Victims Compensation Commission	14 CPS 06019	03/30/15	30:01 NCR 89
DEPARTMENT OF HEALTH AND HUMAN SERVICES			
Sunrise Clinical Associates PLLC. v. Alliance Behavioral Healthcare, NCDHHS	14 DHR 01503	04/02/15	30:01 NCR 97
Fidelity Community Support Group Inc. v. Alliance Behavioral Healthcare, NCDHHS	14 DHR 01594	04/02/15	30:01 NCR 133
OFFICE OF STATE HUMAN RESOURCES (formerly OFFICE OF STATE PERSONNEL)			
Deni Crawley v. NCDPS Foothills Correctional Institution	13 OSP 11438	04/28/15	30:01 NCR 62
Deni Crawley v. NCDPS Foothills Correctional Institution	13 OSP 19135	04/28/15	30:01 NCR 62

STATE OF NORTH CAROLINA	IN THE OFFICE OF ADMINISTRATIVE HEARINGS
COUNTY OF BURKE	13 OSP 11438 and 13 OSP 19135

DENI L. CRAWLEY,
Petitioner,

V.

NCDPS FOOTHILLS CORRECTIONAL INSTITUTION,
Respondent.

FINAL DECISION

This contested case was heard by Administrative Law Judge Donald W. Overby on March 20, 2015 at Burke County Courthouse in Morganton, North Carolina.

APPEARANCES

For Petitioner:
Kirk J. Angel
The Angel Law Firm, PLLC
Post Office Box 1296
Concord, N.C. 28026

For Respondent:
Tamika Henderson
Assistant Attorney General
North Carolina Department of Justice
Post Office Box 629
Raleigh, North Carolina 27602

Vanessa N. Totten
Assistant Attorney General
North Carolina Department of Justice
Post Office Box 629
Raleigh, North Carolina 27602

PRELIMINARY MATTERS

On March 20, 2015, Petitioner filed a Stipulation of Dismissal with Prejudice in File Number 13 OSP 11438, which contained issues of retaliation, hostile work environment and discrimination. Therefore, contested case, File Number 13 OSP 11438, is closed.

File Number 13 OSP 19135 is properly before this Tribunal and appropriate for disposition,

ISSUE

Whether Respondent had just cause to terminate Petitioner for unacceptable personal conduct on July 29, 2013?

WITNESSES

Called by Respondent:

Petitioner
Jimmy Hassen, Sergeant
Larry Williamson, Assistant Superintendent of Program II
Harvey Suttles, Assistant Unit Manager
David Mitchell, Correctional Administrator
LaDonna Browning, Superintendent
Roger Moon, Regional Director (retired)
Richard Thomas, Assistant Superintendent of Custody and Operations (offer of proof)

Called by Petitioner:

None

EXHIBITS

The following were exhibits admitted on behalf of Respondent except as otherwise indicated ("R. Ex."):

R. Ex. 2:	January 13, 2012	Written Warning for Unsatisfactory Job Performance
R. Ex. 3:	January 13, 2013	Employee Action Plan
R. Ex. 4:	January 15, 2013	Memo from LaDonna Browning to Roger Moon regarding incident occurring on December 19, 2012 concerning Inmate Medlin
R. Ex. 5:	February 12, 2013	Written Warning for Unsatisfactory Job Performance
R. Ex. 13.	April 15, 2013	Zachary Whitfield Grievance
R. Ex. 14:	May 24, 2013	Memo from R. David Mitchell to Roger Moon re: Investigative Summary-undue familiarity and attempted workplace harassment - Zackary Whitfield

R. Ex. 15:	May 9, 2013 (start date)	Transcript between Petitioner and Inmate Zachary Whitfield
R. Ex. 16:	May 10, 2013	Memo to Petitioner from LaDonna Browning regarding Temporary Duty Assignment
R. Ex. 17:	June 13, 2013	Memo to Petitioner from LaDonna Browning regarding Notification of Pre-Disciplinary Conference
R. Ex. 18:	June 14, 2013	Pre-disciplinary Conference Acknowledgment Form
R. Ex. 19:	June 14, 2013	Petitioner's Internal Investigation Statement
R. Ex. 20:	July 24, 2013	Letter to Petitioner from LaDonna Browning regarding Notice of Second Pre-Disciplinary Conference
R. Ex. 21:	July 25, 2013	Pre-Disciplinary Conference Acknowledgment Form
R. Ex. 22:	July 25, 2013	Petitioner's Internal Investigation statement
R. Ex. 23:	June 17, 2013	LaDonna Browning internal Investigation statement
R. Ex. 24:	June 20, 2013	R. David Mitchell internal Investigation statement
R. Ex. 25:	June 14, 2013	Memo to Petitioner from LaDonna Browning regarding recommendation for disciplinary action
R. Ex. 26:	June 17, 2013	Letter from LaDonna Browning to Roger Moon regarding recommendation requested - disciplinary action
R. Ex. 27:	June 20, 2013	Memo from Roger Moon to George Solomon regarding recommended personnel action
R. Ex. 28:	July 29, 2013	Letter to Petitioner regarding Notice of Dismissal for unacceptable personal conduct
R. Ex. 29:	February 10, 2003	Memo signed by Petitioner regarding personal relationships between staff and offenders
R. Ex. 30:	September 19, 2013	Petitioner's Staff Training History
R. Ex. 32:	October 7, 2013	Employee Relations Committee finding of upholding dismissal
R. Ex. 33:	July 20, 2012	General Institution Procedures - Conduct of Employees

R. Ex. 34:	August 16, 2010	State of NC - Department of Correction - Division of Prisons - Conduct of Employees
R. Ex. 35:	October 1, 1005	Department of Correction - Personnel Manual - disciplinary Policy and Procedures
R. Ex. 36:	March 1, 2001	Department of Correction - Personnel Manual - unlawful workplace harassment and professional conduct policy
R. Ex. 38:	October 6, 2014	Petitioner's Responses to Respondent's First Set of Interrogatories and Request for Production of Documents
R. Ex. 40:	May 9, 2013	Audio between Petitioner and Inmate Zachary Whitfield

No exhibits were admitted on behalf of Petitioner.

BASED UPON careful consideration of the sworn testimony of witnesses presented at the hearing, documents received and admitted into evidence, and the entire record in this proceeding as appropriate for consideration, the Undersigned makes the following Findings of Fact. 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 the witness; any interest, bias or prejudice the witness may have; the opportunity of the witness to see, hear, know and remember the facts or occurrences about which the witness testified; whether the testimony of the witness is reasonable; and whether such testimony is consistent with all other believable evidence in the case:

BASED UPON THE foregoing Findings of Fact and upon the preponderance or greater weight of the evidence in the whole record, the Undersigned makes the following:

FINDINGS OF FACT

1. The parties are properly before the Office of Administrative Hearings on a Petition for Contested Case pursuant to Chapters 126 and 150B of the North Carolina General Statues and the Office of Administrative Hearings has jurisdiction over both parties and subject matter as such. To the extent that Findings of Fact contain Conclusions of Law, or that the Conclusions of Law are Findings are Fact, they should be so considered without regard to the given labels.

2. Petitioner began work for Respondent on November 30, 1998 as a Correctional Officer at Foothills Correctional Institution ("Foothills CI") in Morganton, N.C.

3. In 2009, Petitioner became a Case Manager at Foothills CI. As a Case Manager, she was responsible for meeting with inmates once a month to assist them with school and other programs while entrusted to the custody of the North Carolina Department of Public Safety ("NCDPS").

4. In furtherance of her job duties as a case manager, Petitioner was required to provide supportive counseling and answer and follow up on inmate questions and problems.

5. All inmates are assigned to a Case Manager, whose task is to follow the case management process that is implemented by the facility. This process establishes a system in which Case Managers assist and guide inmates in making adjustments to confinement, as well as preparing for a successful reentry into the community.

6. Petitioner was dismissed from her position as a Case Manager effective July 29, 2013 for unacceptable personal conduct for engaging in undue familiarity with an inmate, fostering an unharmonious working environment against another DPS employee by alleging he treated an inmate unfairly and was a racist, and providing false information during an internal investigation. (R. Ex. 28)

7. At the time of Petitioner's dismissal, she had two active written warnings based on unsatisfactory job performance for failing to properly enter case management notes. The first written warning letter was issued on January 13, 2012 and the second written warning letter was issued on February 12, 2013. Both written warnings advised Petitioner that future performance or conduct incidents could result in additional disciplinary action up to and including dismissal. (R. Exs. 2,5) Petitioner was also placed on Employee Action plans to assist her with improving her job performance. (R. Exs. 3,5)

8. The circumstances leading up to Petitioner's dismissal began on April 15, 2013, when Inmate Zachary Whitfield submitted an Administrative Remedy Procedure, or grievance, to Foothills CI dated April 12, 2013.

9. The NCDPS allows inmates to voice his or her concerns through an Administrative Remedy Procedure, which is also known as the Grievance Procedure. Generally, a grievance is written by an inmate expressing concerns about an action, incident, alleged policy violation, or condition within the prison. The grievance will be investigated in a timely manner and the inmate is to receive a written response following the investigation. If the inmate is not satisfied with the result, the inmate may appeal to the facility Superintendent.

10. Inmate Whitfield's complaint alleged that Larry Williamson, Assistant Superintendent for Programs, had treated him "unequally" and had discriminated against him during a recent custody level review. (R. Ex. 13) Whitfield is a white male and Williamson is a black male.

11. Whitfield's grievance was accepted on April 16, 2013 by Harvey Suttles, Assistant Unit Manager, who was designated as the inmate grievance screener on D-Unit at Foothills CI.

12. Whitfield was interviewed by Suttles to discuss the grievance. According to Suttles, Whitfield seemed to be somewhat hostile during the time Whitfield was in his office. Whitfield told Suttles that his Case Manager had told him to write the grievance. Suttles found out that Petitioner was assigned as Whitfield's Case Manager.

13. Suttles sent the grievance to Williamson for a response as Williamson was the Step 2 reviewer for Foothills CI. (R. Ex. 13) The grievance was sent to Williamson even though the grievance revolved around Williamson's actions.

14. On April 18, 2013, Williamson reviewed the grievance which had been filed by inmate Whitfield on April 15, 2013. Williamson requested that Suttles bring the inmate to his office to discuss the allegations.

15. During his meeting with Whitfield, Williamson could sense that Whitfield was disgruntled about his custody promotion being denied. Williamson explained why his promotion was denied. Following that conversation Whitfield alleged that his Case Manager had told him to write the grievance.

16. Inmate Whitfield told Williamson that his case manager had informed him that Williamson was racist and that he would promote a black inmate to a different custody level, but he would not promote a white inmate. Upon hearing the allegations, Williamson immediately removed himself from the process because the allegations were concerning him.

17. According to Williamson, before Whitfield could state the name of his Case Manager, Williamson stopped him from talking, and instructed Suttles to escort Whitfield to Richard Thomas, Assistant Superintendent for Operations, office. At that point Williamson did not check to see who Whitfield's case manager was, although very soon thereafter he confirmed that Petitioner was in fact his case manager.

18. No evidence was submitted to this Tribunal to prove that Williamson was aware of the identity of Whitfield's Case Manager following the discussion between the two. While it might be assumed that Williamson knew, there is no evidence at all to confirm such assumption.

19. Williamson was concerned about the allegations that he was in any way a racist because Foothills CI population consists of inmates who have committed assaults, murder and some belong to gangs. Among the prison's population are white supremacists who have a tendency to be violent. Williams feared that he could be attacked, if it was rumored that he was racist or unfair toward white inmates.

20. Williamson's fear was reasonable that he would be a prime target for white supremacist or others if it was rumored that he was racist or unfair toward white inmates.

21. Once Suttles had escorted the inmate to his office, Thomas interviewed Whitfield concerning the grievance that he had filed. Suttles and Captain Harold Reep were present. Whitfield informed Thomas that Petitioner was his Case Manager and that she had instructed him to submit the grievance.

22. The inmate completed a written statement dated April 18, 2013 about the specific allegations reported by him to Mr. Thomas. (R. Ex. 14)

23. Petitioner's contentions that there is no credible evidence to prove that Suttles or Harold Reep were present during the interview, and that there is no credible evidence to prove that Whitfield voluntarily agreed to write the statement are without merit. There is no evidence presented to contradict the sworn testimony concerning the evidence of who was present and the voluntariness of Whitfield's statement.

24. The evidence is clear that inmate Whitfield's case manager was Petitioner.

25. In early May 2013, the NCDPS began a formal misconduct investigation into

allegations of inappropriate conduct and undue familiarity between inmate Whitfield and Petitioner at Foothills CI.

26. There was no evidence presented in this contested case hearing concerning Whitfield's grievance in relation to Williamson; however, that was not the issue in this contested case hearing and thus it is irrelevant. If that grievance had relevance in this hearing, it was the Petitioner's burden to produce such information. A blanket assertion without any proof at all has no probative value and is unsupported.

27. At all relevant times, the Western Regional Director was Roger Moon. Director Moon designated David Mitchell as the primary investigator. (R. Ex. 14)

28. At all relevant times, Mitchell was the Operational Manager for the Western Regional Office. Earlier Mitchell had mediated a grievance Petitioner had against Respondent.

29. On or about May 2, 2013, as part of this investigation, Mitchell decided to place a recording device on inmate Whitfield to tape record a conversation between Whitfield and Petitioner in order to substantiate inmate Whitfield's allegations. The investigation was also to obtain direct evidence and corroborate inmate Whitfield's allegations regarding Petitioner which constituted undue familiarity and inappropriate conversation.

30. Petitioner was to return to work following vacation on May 9, 2013. On May 8, 2013, the recording device was supplied by Mitchell to Thomas. Mitchell tested the recording device to insure its proper functioning prior to providing the device to Thomas. On May 9, 2013 Whitfield was brought to Thomas's office and Thomas turned the recording device on and placed it in the front pocket of the inmates' jumpsuit. The recorder was not very well concealed.

31. Sergeant Jimmy Hassen immediately escorted inmate Whitfield to Petitioner's office. Hassen and Whitfield made no stops, did not touch or manipulate the recording device and went directly to Petitioner's office. On May 9, 2013, the recording device located on the person of Whitfield captured a continuous conversation between Petitioner and Inmate Whitfield, which lasted approximately eighteen minutes. (R. Ex. 40) Hassen remained directly outside of Petitioner's office the entire time that Whitfield was in her office.

32. As soon as Whitfield came out of Petitioner's office, Hassen took the inmate from Petitioner's office directly to Thomas' office. Thomas and Browning checked to ensure that the recording device had captured the conversation by turning it on and ensuring that they heard voices. Thomas then called Mitchell.

33. Mitchell came and retrieved the audio recording from Thomas. That is the totality of people who had the care and/or custody of the recording device, or access to it, from the time Mitchell had delivered it to Thomas until Mitchell retrieved it from Thomas. There is no evidence that the recorder was tampered with in any regard.

34. The undersigned finds as fact that the recording device produced an audio recording of the May 9, 2013 conversation between inmate Whitfield and Petitioner.

35. The following day Petitioner was interviewed by Mitchell and LaDonna Browning,

the Superintendent of Foothills CI.

36. Prior to the interview on May 10, 2013, Petitioner was reminded that NCDPS written workplace rules and investigatory procedure require her to provide completed and accurate information and that the penalty for providing false, incomplete and/or misleading information during the investigation was dismissal. Petitioner acknowledged those requirements and, in accordance with NCDPS published investigatory procedures, signed a written acknowledgment of those requirements before the interview began. Mitchell witnessed Petitioner's signature. (R. Ex. 14)

37. On May 10, 2013, after reading and signing the Internal Investigation Acknowledgment form, Petitioner was interviewed regarding the allegations that she engaged in undue familiarity with inmate Whitfield and fostered an unharmonious working environment. (R. Ex. 14)

38. Petitioner's interview consisted of sixteen questions specifically prepared by Mitchell after listening to the recording regarding Petitioner's interaction with inmate Whitfield on May 9, 2013 and April 11, 2013. Petitioner was then asked to respond in writing to the prepared questions.

39. In the written statement, Petitioner admitted that she engaged in a conversation with the inmate, but denied that she used profanity, that she discussed her personal information or that she discussed Williamson. (R. Ex. 14). The undersigned finds as fact that the foregoing assertions by the Petitioner were false.

40. Mitchell subsequently played audio segments of Petitioner and Inmate Whitfield's conversation on May 9, 2013.

41. After hearing the audio recording, Petitioner denied it was her voice on the tape.

42. Mitchell and Browning, listened to the audio recording on May 9, 2013. Mitchell and Browning were familiar and had personal knowledge of inmate Whitfield and Petitioner's voice. Browning testified that she had worked with the Petitioner for 13 years and was familiar with her voice. Both Mitchell and Browning confirmed that the voice on the audio recording was inmate Whitfield and Petitioner. (R. Ex. 40). Moreover, the contents of the tape corroborate this identification testimony. The male on the recording addresses the female on the recording as Ms. Crawley. More importantly, the female voice intentionally speaking about herself in third person when directing the inmate what not to say to other prison employees refers to herself as Ms. Crawley.

43. Subsequent to listening to the entire audio recording at hearing, Browning confirmed that the audio recording was the same recording she heard on May 9, 2013 and the voice was that of the Petitioner.

44. Whitfield's presence for the hearing or his unavailability was never raised as an issue during the hearing of this matter.

45. At the hearing, Petitioner testified and the audio recording was played in part and in its entirety twice. The female voice on the audio recording was the voice of Petitioner. (R. Ex. 40)

46. During this May 9, 2013 taped conversation, Petitioner repeatedly used profanity in speaking to inmate Whitfield. Petitioner discussed various personal topics with inmate Whitfield, to include that her daughters were biracial, and that she had written a grievance against Williamson. Petitioner also told the inmate not to "sell me out. . .Like I said I've got children to feed." (R. Exs. 15, 40)

47. DPS policy prohibits the use of profanity in the presence of inmates. During her testimony the Petitioner conceded that use of profanity in the presence of inmates violates DPS policy.

48. During Petitioner's interaction with inmate Whitfield, she repeatedly made disparaging comments about Williamson. These comments included that he was racist against whites, biased against women and a suggestion that he was only given his position with DPS because he was an educated minority. Petitioner also suggested that Williamson wasn't allowing her to give the inmate a lower custody classification which would allow him to have less restrictions, because the inmate was white. (R. Exs. 15, 40)

49. The Petitioner fostered an unharmonious working environment for Williamson, a DPS employee, by alleging to inmate Whitfield that Williamson was racist and that Williamson treated the inmate unfairly. Petitioner's conduct violated NCDPS Personnel policy, Section 3, Unlawful Workplace Harassment and Professional Conduct, Professional and Acceptable Personal Conduct. (R. Ex. 36)

50. Petitioner's conduct created a very real potential for harm considering the inmate population served at Foothills CI and the potential for inmates to physically attack Williamson based on the perception that he was racist towards whites.

51. The Petitioner signed a memorandum acknowledging the personal dealings with offenders on February 10, 2003. This included that Petitioner was required to report any personal interactions with an inmate at the same work site. (R. Ex. 29, 45)

52. During the internal investigation, Petitioner was temporarily reassigned to Western Youth Institution on May 10, 2013. (R. Ex. 16).

53. After hearing the testimony and observing the demeanor of Petitioner, Williamson, Suttles, Hassen, Browning and Mitchell at trial, the Undersigned finds as fact that Williamson, Suttles, Hassen, Mitchell and Browning accounts of the events concerning May 9, 2013 and the internal investigation are more credible than Petitioner.

54. Petitioner provided false and misleading information in her internal investigation

interview and written statements in violation of the NCDPS, Section 6, Disciplinary Policy and Procedures, failure to cooperate during or hindering an internal investigation policy.

55. The audio recording on May 9, 2013 was reduced to a type-written transcript by Mitchell. The transcript and the actual audio recording were provided to Regional Director Moon along with the investigation report and written statements. (R. Exs. 14, 15, 40)

56. After careful consideration, Regional Director Moon recommended to George Solomon, Director of Prisons, that Petitioner be dismissed for unacceptable personal conduct. The recommendation was approved through the chain of command. (R. Ex. 27)

57. Prior to Petitioner's dismissal, Respondent afforded Petitioner a pre-disciplinary letter and a pre-dismissal conference. (R. Exs. 17, 18, 20, 21)

58. During the pre-dismissal conference Petitioner was given the opportunity to respond to the allegations against her contained in the pre-disciplinary conference notification letter.

59. Respondent sent and Petitioner received a Dismissal letter terminating her employment and afforded Petitioner the opportunity to administratively appeal her termination. (R. Ex. 28)

60. After completing her internal agency appeals, Petitioner filed this contested case at the OAH on November 6, 2013. In her contested case petition, the Petitioner alleged that Respondent lacked "just cause" to end her employment for disciplinary purposes.

BASED UPON the foregoing Findings of Fact and upon the preponderance or greater weight of the evidence in the whole record, the Undersigned makes the following:

CONCLUSIONS OF LAW

1. This matter is properly before the Office of Administrative Hearings for consideration pursuant to Chapters 126 and 150 B of the North Carolina General Statutes.

2. NCDPS Personnel policy, Section 3, Unlawful Workplace Harassment and Professional Conduct, Professional and Acceptable Personal Conduct states: "It is the responsibility of every employee and agent of the Department to conduct himself or herself in a manner that contributes to a workplace environment that is not only free of unlawful workplace environment harassment but also advances the mission and goals of the Department and fosters a harmonious working environment that encourages all employees to perform at their best."

3. The NCDPS, Division of Prisons has a policy governing the personal conduct of its employees and interactions with inmates and the public. The personal conduct policy is found in the Division of Prisons Policy and Procedures Manual, Chapter A, Section .0200, Conduct of Employees. Sub-section .0202 (f)(1) provides that, "Employees will maintain a quiet but firm demeanor in their dealings with inmates and will not indulge in undue familiarity with them. Whenever there is reason for discussing an inmate's problems with him, employees will exhibit a helpful but

professional attitude. No employee will discuss his or her personal affairs with an inmate." (R. Ex. 34 p. 3) Violations of this policy may result in disciplinary action including dismissal. (R. Ex. 34 p. 4)

4. Foothills CI also has a policy governing the personal conduct of its employees and interactions with inmates and the public. The personal conduct policy is found in the Foothills CI, General Institution Procedures, Chapter 1, Section .0800, Conduct of Employees. The Foothills CI conduct policy incorporates the NCDPS, Section .0200 and NC DPS Personnel Manual Section 6 policies by reference. Section XII (1) reiterates the importance of employees not indulging in unfamiliarity with inmates or discussing their personal affairs with inmates as stated in Division of Prisons, Sub-section .0202(f)(1). (R. Ex. 33 p 8)

5. The NCDPS, Disciplinary Policy and Procedures include a policy governing employee's conduct during internal investigations. Section 6, Disciplinary Policy and Procedures, Failure to Cooperate during or hindering an internal investigation policy provides that, "Employees are required to cooperate during such investigations by displaying truthfulness and honesty. An employee's failure to cooperate with Department officials or hindering an internal investigation constitutes unacceptable personal conduct and is representative of those causes considered for disciplinary action up to and including dismissal. Additionally, providing false or purposefully misleading information during the course of an internal investigation or discussing any aspect of the investigation with anyone other than the investigative personnel also constitutes unacceptable personal conduct and is representative of those causes considered for disciplinary action up to and including dismissal." (R. Ex. 35)

6. Petitioner was dismissed from State service for engaging in undue familiarity with an inmate, fostering an unharmonious working environment against another DPS employee by alleging he treated an inmate unfairly and was a racist, and providing false information during an internal investigation. Respondent contends that Petitioner's conduct constitutes "Unacceptable Personal Conduct" ("UPC") as defined in 25NCAC 01 J .0614(8).

7. Petitioner is a "career state employee" as defined by N.C.G.S. § 126-1.1. As a career state employee, she could only be dismissed for "just cause." N.C.G.S. § 126-35; 25 NCAC 01J .0604.

8. UPC may be, among other things, "(a) conduct for which no reasonable person should expect to receive prior warning;. . .(d) the willful violation of known or written work rules;. . . [or] (e) conduct unbecoming a state employee that is detrimental to state service[.]"
25NCAC 01 J .0614 (8)(a),(d),(e).

9. "Employees may be dismissed for a current incident of unacceptable personal conduct, without any prior disciplinary action." 25 N.C.A.C. 1J. 0608(a).

10. Respondent complied with the procedural requirements for dismissal for unacceptable personal conduct pursuant to 25 N.C.A.C. 01J .0608 and .0613.

11. Although "just cause" is not defined by statute or rule, the words are to be accorded their ordinary meaning. *Amanini v. Dep't of Human Resources*, 114 N.C. App. 668, 443 S.E.2d 114 (1994) (defining "just cause" as, among other things, good or adequate reason).

12. While "just cause" is not susceptible of precise definition, our courts have held that it is "a flexible concept, embodying notions of equity and fairness that can only be determined upon an examination of the facts and circumstances of each individual case." *NC DENR v. Carroll*, 358 N.C. 649, 669, 599 S.E.2d 888, 900 (2004).

13. In *Carroll*, 358 N.C. 649, 599 S.E.2d 888 (2004), the Supreme Court states that the fundamental question in determining just cause is whether the disciplinary action taken was just. Citing further, "Inevitably, this inquiry requires an irreducible act of judgment that cannot always be satisfied by the mechanical application of rules and regulations." Our Supreme Court said that there is no bright line test to determine "just cause"--it depends upon the specific facts and circumstances in each case."

14. In *Carroll*, the Court went on to say that "not every violation of law gives rise to 'just cause' for employee discipline." In other words, not every instance of unacceptable personal conduct as defined by the Administrative Code provides just cause for discipline. *Id.* at 670, 599 S.E.2d at 901.

15. Further, the Supreme Court held that, "Determining whether a public employee had 'just cause' to discipline its employee requires two separate inquires: First, whether the employee engaged in the conduct the employer alleges, and second, whether that conduct constitutes 'just cause' for the disciplinary action taken." *Id.*, 358 N.C. at665, 599 S.E.2d at 898.

16. In expounding on *Carroll*, the Court of Appeals in the *Warren* case articulates the tests that courts must consider in assessing whether or not discipline is proper and if so the degree of discipline. Warren establishes a commensurate discipline approach to discipline in North Carolina. It states:

> We conclude that the best way to accommodate the Supreme Court's flexibility and fairness requirements for just cause is to balance the equities after the unacceptable personal conduct analysis. This avoids contorting the language of the Administrative Code defining unacceptable personal conduct. The proper analytical approach is to first determine whether the employee engaged in the conduct the employer alleges. The second inquiry is whether the employee's conduct falls within one of the categories of unacceptable personal conduct provided by the Administrative Code. Unacceptable personal conduct does not necessarily establish "just cause" for all types of discipline. If the employee's act qualifies as a type of unacceptable conduct, the tribunal proceeds to the third inquiry: whether that misconduct amounted to "just cause" for the disciplinary action taken. (Internal cites omitted.)

Warren v. North Carolina Dep't of Crime Control & Pub. Safety, 221 N.C. App. 376, 382-383, 726 S.E.2d 920, 924-925 (2012) *review denied*, 735 S.E.2d 175 (2012).

17. The Undersigned finds by a preponderance of the evidence that Petitioner did engage in the conduct alleged by Respondent; i.e., Petitioner did engage in undue familiarity with an inmate;

fostered an unharmonious working environment; and provided false information during an internal investigation.

18. The second test under *Warren* is whether or not Petitioner's conduct falls within one of the categories of unacceptable personal conduct.

19. Respondent contends that Petitioner's conduct was a "willful violation of known or written work rules." 25NCAC 01 J .0614 (8)(d).

20. A willful violation of known or written work rules occurs when an employee "willfully takes action which violates the rule and does not require that the employee intend [the] conduct to violate the work rule." *Teague v. N. Carolina Dep't of Transp.*, 177 N.C. App. 215, 222, 628 S.E.2d 395, 400 (2006), *citing Hilliard v. N. C. Dept. of Correction*, 173 N.C .App. 594, 620 S.E.2d 14 (2005). Actual knowledge of the work rules is not required.

21. Petitioner's conduct was a "willful violation of known or written work rules."

22. The preponderance of evidence showed that Petitioner exhibited poor judgment in engaging in undue familiarity with an inmate, making disparaging comments that another NCDPS employee was racist and unfair, repeatedly using profanity and hindering an internal investigation by providing false information.

23. The credible evidence showed that Petitioner's conduct created a serious threat to another NCDPS employee's life and well-being among inmates at Foothills CI.

24. The preponderance of evidence showed that Petitioner's conduct was conduct unbecoming a state employee that is detrimental to state service.

25. In the case of "conduct unbecoming a state employee that is detrimental to state service," the State employer is not required to make a showing of actual harm, "only a potential detrimental impact (whether conduct like the employee's could potentially adversely affect the mission or legitimate interests of the State employer)." *Hilliard*, 173 N.C. App. at 597, 620 S.E.2d at 17.

26. Thus, the Petitioner's conduct falls within two of the categories of unacceptable personal conduct provided by the Administrative Code as set forth as the second requirement in *Warren*.

27. The preponderance of evidence showed that Respondent had two active written warnings. *See* 25 N.C.A.C. 1J.0604, 25 N.C.A.C. 1J.0605. Respondent appropriately considered Petitioner's prior written warnings when ascertaining the appropriate level of discipline to impose.

28. It is well settled that judgment should be rendered in favor of the State agency when the evidence presented establishes that the employee committed at least one of the acts for which she was disciplined. *Id.*, 173 N.C. App. at 597, 620 S.E.2d at 17.

29. One act of unacceptable personal conduct can present just cause for any discipline of an employee, up to and including dismissal.

30. The undersigned admitted the audio recording into evidence over Petitioner's objection. Pursuant to Rule 901 of the North Carolina Rules of Evidence testimony, as to accuracy based on personal knowledge is all that is required to authenticate a tape recording, and a recording so authenticated is admissible. *State v. Jones*, N.C. 330, 344-45, 595 S.E.2d 124, 134(quoting State v. Stager, 329 N.C. 278, 317, 406 S.E.2d 876, 898 (1991). The undersigned finds that the testimony of Mitchell and Browning was sufficient to both identify the voices on the audio recording and to authenticate its contents pursuant to Rule 901. Moreover, the tapes contents corroborate the identification testimony. *See State v. West*, 317 N.C. 219, 345 S.E.2d 186 (1986)(audio recording found on side of the road was properly authenticated and admitted into evidence based on testimony of victim and investigating sheriff who were familiar with the Defendant's voice. Additionally, the contents of the recording corroborated the identification testimony).

31. Petitioner engaged in undue familiarity on May 9, 2013 with inmate Whitfield in violation of Division of Prisons Policy and Procedures Manual, Chapter A, Section .0200, Conduct of Employees. Sub-section .0202 (f)(1) and the Foothills CI, General Institution Procedures, Chapter 1, Section .0800, Conduct of Employees policies. (R. Exs. 33, 34)

32. Based upon the totality of evidence just cause exists to discipline the Petitioner and the "just" discipline for Petitioner is that she be dismissed. Accordingly, Petitioner's termination is **upheld.**

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law the Respondent's decision to terminate Petitioner's employment is **AFFIRMED.**

NOTICE AND ORDER

THIS IS A FINAL DECISION issued under the authority of N.C.G.S. § 150B-34. Under the provisions of N.C.G.S. § 126-34.02(a): "An aggrieved party in a contested case under this section shall be entitled to judicial review of a final decision by appeal to the Court of Appeals as provided in G.S. 7A-29(a). The procedure for the appeal shall be as provided by the rules of appellate procedure. The appeal shall be taken within 30 days of receipt of the written notice of final decision. A notice of appeal shall be filed with the Office of Administrative Hearings and served on all parties to the contested case hearing."

In conformity with the Office of Administrative Hearings' Rules, and the Rules of Civil Procedure, N.C.G.S. § 1A-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.

Under N.C.G.S. § 150B-47, the Office of Administrative Hearings is required to file the official record in the contested case with the Clerk of the Court of Appeals 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.

IT IS SO ORDERED.

This the 28th day of April, 2015

The Honorable Donald W. Overby
Administrative Law Judge

STATE OF NORTH CAROLINA	Filed	IN THE OFFICE OF ADMINISTRATIVE HEARINGS
COUNTY OF WAKE	2015 MAR -3 PM 4:	FILE NO. 14 BOA 4954
	Office of Administrative Hearings	
NORTH CAROLINA BOARD OF ARCHITECTURE, Petitioner,	)	
vs.	)	**PROPOSAL FOR DECISION**
ANTHONY V. HUNT Respondent.	)	

Pursuant to N.C. Gen. Stat. § 150B-40(e) and § 83A-15, on July 3, 2014, Petitioner filed a petition with the Office of Administrative Hearings requesting designation of an Administrative Law Judge to hear this case, and make a Proposal for Decision to the North Carolina Board of Architecture ("Petitioner" or "Petitioner Board"). On December 15, 2014, Administrative Law Judge Melissa Owens Lassiter heard this case in Raleigh, North Carolina. On January 13, 2015, the undersigned issued an Order for the parties to file proposed Proposals for Decision within thirty days of receiving the transcript. On February 12, 2014, Petitioner filed a proposed Proposal for Decision with the Office of Administrative Hearings.

APPEARANCES

For Petitioner: M. Jackson Nichols
Anna Baird Choi
Catherine E. Lee
Allen, Pinnix & Nichols, P.A.
510 Glenwood Ave., Suite 301
Raleigh, NC 27602

For Respondent: Kevin P. Byrnes
604 Oakland Avenue
Post Office Box 5486
Charlotte, NC 28299

ISSUES

1. Whether Respondent engaged in dishonest conduct, in violation of N.C. Gen. Stat. § 83A-15(a)(1)a, by failing to pay a subcontractor monies owed after the client paid those funds to Respondent for that purpose?

2. Whether Respondent misrepresented himself in a professional relationship in violation of N.C. Gen. Stat. § 83A-15(a)(1)a?

3. What disciplinary action should Petitioner impose upon Respondent under N.C. Gen. Stat. §83A-15?

4. What amount of civil penalty should Petitioner imposed upon Respondent under N.C. Gen. Stat. § 83A-15?

WITNESSES

For Petitioner: Cathe Evans, Avery Monroe, Charles Boney, Jr.

For Respondent: Anthony Hunt

EXHIBITS ADMITTED INTO EVIDENCE

For Petitioner: 1 – 10, 12, 15 – 17, 19 - 42, 44 – 46

For Respondent: 1 – 4, 6, 8, 12, 13

FINDINGS OF FACT

Procedural Background

1. On July 3, 2014, Petitioner Board filed a petition for contested case hearing with the Office of Administrative Hearings alleging that Respondents had engaged in acts or omissions in violation of N.C. Gen. Stat. § 83A-15(a)(1)a.

The Parties

2. Petitioner Board is a statutorily-created occupational licensing agency that is tasked with protecting the health, welfare and safety of the public through its licensure and discipline of architects in North Carolina. T.102:25-103:9; Pet. Ex. 44.

3. The Professional Standards Committee ("PSC") is a committee of the Petitioner that accepts, processes, and investigates disciplinary and ethics matters regarding licensees. T. 28:18-29:19; 100:15-22. If Petitioner determines that grounds for discipline exist, then it will issue discipline or a letter of caution/letter of warning. T. 28:18-29:19.

4. In 1991, Petitioner issued a license to practice architecture to Respondent. T. 17:15-17. As a licensee, Respondent is subject to the statutes and rules governing the practice of architecture in North Carolina.

5. In August 2000, Millennium 3 Design Group, PLLC ("M3DG") created Articles Of Organization, and began the process of filing such Articles Of Organization with the North Carolina Secretary of State ("Secretary of State"). Pet. Ex. 3. In connection with that filing, Petitioner Board certified to the Secretary of State that M3DG had a duly-licensed architect as a member of the firm. T. 19:15-20:10. In February 2001, the Secretary of State certified that such Articles Of Organization had been properly filed. Pet. Ex. 4.

6. N.C. Gen. Stat. § 83A-8 provides that:

> Such corporations shall designate the individual or individuals licensed to practice architecture in this State who shall be **in responsible charge** of all architectural work offered or performed by such corporation in this State.

Pet. Ex. 44. (Emphasis added)

7. For all times relevant to this proceeding, Respondent was the architect "in responsible charge" at M3DG. T. 18:24-21:22; Pet. Ex. 3. To be "in responsible charge" means that Respondent was responsible for all work and services performed by M3DG, and was responsible for its compliance with Petitioner's statute and regulations. T. 21:6-16; 103:18-104.

Witnesses

8. Cathe Evans has been employed as the Petitioner's Executive Director since 2001. T.14:22-15:3. As Executive Director, Ms. Evans is in charge of the day-to-day administrative activities of Petitioner. She deals with all of the financial aspects of the Petitioner, and assists Petitioner's Professional Standards Committee in handling all disciplinary actions. T. 15:7-13.

9. Since June 2001, Avery Monroe has been employed by RMF Engineering ("RMF") as a project manager. T. 71:21-72:8. He currently serves as Director of the Charlotte office of RMF Engineering, and is licensed as a Professional Engineer in North Carolina. T. 71:6-8. As project manager, Mr. Monroe is responsible for staffing projects, and ensuring that the projects are delivered and on budget. T. 72:9-13.

Expert Witness

10. Charles Boney, Jr. serves as Vice President and Studio Director of Public Projects for LS3P Associates, an architectural firm in Wilmington, North Carolina. T. 91:21-92:19.

11. Mr. Boney is an architect who has been continuously licensed by the Petitioner since 1984. T. 94:3-11. Petitioner has never imposed any disciplinary action against Mr. Boney's license. T. 99:16-20.

12. As an architect, Mr. Boney primarily performs work for public agencies, such as K-12 schools, the University of North Carolina system, community colleges, public health departments, and municipal governments. T. 93:16-23.

13. Mr. Boney's qualifications as an expert witness in the practice of architecture in North Carolina and in the Architectural Practice Act are as follows:

a. Mr. Boney graduated from N.C. State University's College of Design in 1978, and from the University of Pennsylvania graduate School of Fine Arts in 1982. Pet. Ex. 45; T. 94:22-95:7.
b. From 1978 to 1980 and from 1982 until 2005, Mr. Boney worked full-time for Boney Architects. T. 92:17-93:1.
c. In 2005, Boney Architects merged with LS3P Associates. Mr. Boney currently works as an architect for LS3P Associates. T. 92:17-22. Mr. Boney has served as the managing principal of the Wilmington office of LS3P Associates for three years. T. 95:20-25.
d. Mr. Boney has received several awards from various bodies, including: (i) Learning by Design, an awards program in the educational realm, and (ii) the American Institute of Architects. T. 96:15-98:19; Pet. Ex. 45.
e. Mr. Boney has published various books and articles regarding the practice of architecture. T. 98:20-99:15.
f. Mr. Boney served on Petitioner's Board from 2004 until 2013. At various times while serving as a board member, Mr. Boney held the positions of Secretary, Treasurer, Vice President, and President. Mr. Boney served as Petitioner's President for three years, and chaired the PSC in that capacity. T. 99:23-100:14.
g. As Chairman of the PSC, Mr. Boney completed training on a national basis with the National Council of Architect Registration Boards and completed ethics training through the NC Ethics Commission. T. 100:23-101:12.
h. As a former member of Petitioner's Board, and a licensed architect in practice for 30 years, Mr. Boney was required to be, and is familiar with the statutes and rules that govern the practice of architecture in North Carolina. T. 101:13-24.

14. At the contested case hearing, the undersigned accepted Mr. Boney as an expert witness in the practice of architecture in North Carolina, and in the Architectural Practice Act, set forth in Chapter 83A of the North Carolina General Statutes. T. 104:11-105:5. While serving as an expert witness in this contested case, Mr. Boney reviewed the allegations set forth in the Petitioner's petition for contested case hearing. T. 106:14-21. He also reviewed Petitioner's file regarding RMF's complaint against Respondent Hunt. T. 115:21-116:3.

15. At hearing, Mr. Boney opined that Respondent, as a licensed architect designated to be the responsible charge of M3DG, breached his fiduciary

responsibilities to his client, and to his subcontractors when he failed to disburse money that was obligated to the subcontractors. T. 106:22-107:8. Mr. Boney also opined that such breach of his fiduciary duty constituted dishonest conduct in violation of N.C. Gen. Stat. §83A-15(a)(1)a. *Id.*

Hunt's Prior Disciplinary History

16. In 1994, Respondent and Petitioner entered into a Consent Order, which, among other things, imposed a reprimand and a civil penalty of $500.00 on Petitioner. Pet. Ex. 9; T. 33:15-34:10.

17. In 1997, Respondent and Petitioner entered into a Consent Order, which, among other things, imposed a reprimand and a civil penalty in the amount of $750.00. This 1997 Consent Order was predicated on the fact that Respondent had submitted invoices for completion of design services, without actually submitting the final design development plans as required. Pet. Ex. 10; T. 34:11-15; 35:1-23.

18. In November 2004, Petitioner issued a non-disciplinary letter of caution advising Respondent to be familiar with departmental requirements before undertaking projects subject to review by a third party agency, and to communicate clearly in writing the extent or limitation of his services to clients. Pet. Ex. 12; T. 36:3-37:5.

19. In July 2007, North Carolina State University ("NCSU") filed an ethics complaint against M3DG for alleged dishonest conduct, fraud, and unprofessional conduct. Pet. Ex. 15; T. 37:6-20. During that investigation, the PSC determined that, for all times relevant to the NCSU complaint, Respondent was the architect in responsible charge of M3DG who handed the financial arrangements for M3DG. In particular, the PSC determined that Respondent failed to pay subcontractors for work performed, despite having received payment from NCSU for the subcontractors' work. T. 39:16-41:5.

20. In October 2009, Respondent and Petitioner entered into a Consent Order to resolve the complaint filed by NCSU, whereby, among other things, Petitioner issued a reprimand and a civil penalty of $7,500 to Respondent. Pet. Ex. 16; T. 37:21-38:17.

21. In October 2009, Petitioner received another ethics complaint against Respondent which alleged that M3DG had been paid for work that it failed to perform. Pet. Ex. 17; T. 41:6-42:2. In April 2010, Petitioner issued Respondent a letter of caution, advising that "failure to pay subcontractors in a timely manner may result in disciplinary action for unprofessional conduct." Pet. Ex. 19.

22. In October 2012, Petitioner received an ethics complaint against Respondent alleging dishonest conduct, unprofessional conduct, and fraud. Pet. Ex. 20; T. 44:24-45:13. In February 2013, in response to this complaint, Petitioner issued a letter of caution to Respondent warning him that he must maintain attention to detail

when accepting and disbursing payments to individuals in his employ, including but not limited to contractors and consultants. Pet. Ex. 21; T. 45:21-46:9.

Grounds for Discipline

23. In March 2006, RMF submitted a proposal to perform mechanical and electrical engineering services, including design drawings, specifications, bid review, and construction administration, for new student housing at Elizabeth City State University ("ECSU"). Pet. Ex. 25.

24. Respondent accepted RMF's March 2006 proposal, and RMF began working on the ECSU project shortly thereafter. Pet. Ex. 25; T. 75:5-9.

25. Between June 9, 2009 and November 30, 2010, Respondent made no payments to RMF for work performed on the ECSU project, despite being invoiced $41,344.00 during this time. Pet. Ex. 28.

26. On September 30, 2010, Respondent owed RMF $28,105.00 for work performed, of which $23,630.00 was past due. On November 30, 2010, Respondent owed RMF $41,344.00 for work performed, of which $28,105.00 was past due. On April 30, 2011, Respondent owed RMF $15,250.50 for work performed, of which $12,884.50 was past due. On June 30, 2011, Respondent owed RMF $18,928.00 for work performed, of which $15,250.50 was past due. On July 31, 2011, Respondent owed RMF $22,605.50 for work performed, of which $18,928.00 was past due. On September 30, 2011, Respondent owed RMF $29,960.50 for work performed, of which $26,283.00 was past due. On August 31, 2012, Respondent owed RMF $34,429.43 for work performed, of which $29,080.48 was past due. Pet. Ex. 26; T. 76:23-77:3.

27. In July 2011, Mr. Monroe, the project manager for RMF, left Respondent several voicemail messages requesting a return call to discuss M3DG's unpaid invoices. Respondent did not return Mr. Monroe's calls. Pet. Ex. 29; T. 80:4-23.

28. By letter dated September 13, 2011, Mr. Monroe demanded payment from Respondent for RMF's unpaid invoices, and noted M3DG's failure to meet the terms of a payment plan made in February 2011. Mr. Monroe informed Respondent that, unless all owed money was received, RMF would cease its work on the ECSU project immediately upon close of business on September 13, 2011, and advised that RMF would not resume work until full payment was made. Pet. Ex. 30; T. 4-15.

29. Because Respondent did not pay all money owed to RMF, as demanded in RMF's September 13, 2011 letter, RMF ceased work on the ECSU project upon close of business on September 13, 2011. Pet. Ex. 30; T.82:11-17.

30. On September 26, 2011, Respondent sent Mr. Monroe a letter in response, offering to pay the unpaid invoices within 30 days. Pet. Ex. 31; T. 16-22. In that response, Respondent wrote:

> Millennium 3 Design Group (M3DG) acknowledges that its outstanding balance with RMF is for a total amount of 22,605.50 for the Mitchell Lewis Replacement Project.

Id.

31. Because Respondent did not agree to pay all money owed to RMF immediately in the September 26, 2011 proposal, RMF did not accept Respondent's proposal, and did not resume work on the ECSU project. T. 82:11-17.

32. On September 27, 2011, Mr. Monroe sent Respondent a second letter, again demanding full payment. Mr. Monroe did not recall receiving a response from Respondent. T. 82:18-83:5; Pet. Ex. 32.

33. On October 5, 2011, Mr. Monroe sent a third letter to Respondent, again demanding payment of all past due invoices, and seeking assurances that future invoices would be paid. Pet. Ex. 33; T. 83:6-19. By October 5, 2011, RMF still had not resumed work on the ECSU project. T. 83:6-19.

34. On November 10, 2011, Mr. Monroe sent a fourth letter to Respondent, again demanding payment of all past due invoices, and seeking assurances that future invoices would be paid. Pet. Ex. 34; T. 83:20-84:9. Mr. Monroe did not recall receiving a response to the November 10, 2011 letter. T. 84:7-9. By November 10, 2011, RMF still had not resumed work on the ECSU project. T. 84:4-6.

35. Sometime after November 10, 2011, RMF and Respondent reached an agreement that RMF would resume services with the caveat that ECSU would be involved in the arrangements to pay RMF. T. 85:1-85:11. Although Respondent provided RMF with payment on one occasion thereafter, M3DG fell behind on its payments to RMF again. T. 85:12-25.

36. On October 26, 2012, Mr. Monroe sent an email to Mr. Charles Hall at ECSU to determine whether M3DG had been paid for the work performed by RMF. Pet. Ex. 36; T. 86:1-86:19. Mr. Hall confirmed that M3DG had been paid for the work performed by RMF. *Id.*

37. On November 14, 2012, RMF sent an email to Respondent seeking payment for the past due invoice of $47,668.43. Pet. Ex. 37; T. 87:7-18. RMF did not receive a response from Respondent. *Id.*

38. On March 18, 2013, RMF submitted another email to Respondent, again seeking payment for the past due invoice of $47,668.43. Pet. Ex. 38; T. 87:19-88:2. RMF did not receive a response from Respondent. *Id.*

39. In March 2013, Mr. Respondent informed Mr. Monroe that M3DG no longer was in existence and, as a result, RMF would not be paid. T. 88:17-25.

40. ECSU paid Respondent paid in full for the services rendered by RMF. Pet. Ex. 22, RFA 2.

41. Despite repeated requests for payment from RMF, Respondent failed to pay $47,710 owed for completed work that was provided to ECSU. Pet. Ex. 22, RFA 11.

42. On or about September 26, 2011, Respondent wrote a letter to Mr. Monroe, in which Respondent outlined a proposal for payment of monies owed. Pet. Ex. 31. In that letter, Respondent did not raise any concerns about the quality of the work RMF had performed in connection with the project. *Id.*; T. 54.

43. In September 2011, Respondent filed an application with Petitioner to form a new North Carolina Professional Corporation. Resp. Ex. 12.

44. Upon receipt of this application, Petitioner's PSC was concerned that Respondent would start a new company, and dissolve M3DG without fully paying his subcontractors. T. 196:8-197:6. Based upon that concern, Respondent met with the PSC in November 2011 to discuss the PSC's concerns. During that meeting, Respondent informed PSC that he would do his best to not go out of business, and dissolve the firm. T. 1973-6.

45. On May 15, 2012, Respondent filed Articles of Dissolution on behalf of M3DG with the NC Secretary of State. Pet. Ex. 5; T. 22:11-20.

46. Upon filing the Articles of Dissolution, Respondent did not inform the Petitioner that he had dissolved M3DG. T. 22:18-23:9. Petitioner Board did not receive this information until after it had received a complaint from RMF regarding unethical conduct by Respondent for monies owed, and after Respondent began its investigation. T. 25:21-26:12. Typically, architects who are in responsible charge of architectural firms inform Petitioner when their firm has been dissolved. T. 23:4-23:9. Respondent's failure to inform Petitioner Board is indicative of Respondent's intent to hide the fact that he had engaged in fraudulent conversion of the monies owed to RMF.

47. In January 2012, approximately four (4) months before dissolving M3DG, Respondent created Articles of Organization for a new business entity called American Architectural Collaborative, PLLC ("AAC"). Pet. Ex. 7; T. 26:13-27:1. According to the LLC Agreement for AAC, Respondent was the sole member of AAC, and contributed $200.00 in cash to AAC. Pet. Ex. 8. Respondent served "in responsible charge" of AAC. T. 27:2-4

48. On February 14, 2012, Respondent formed a new architecture firm, American Collaborative Design.

49. On May 23, 2012, Respondent dissolved M3D, and claimed that he was no longer obligated to pay RMF the outstanding monies owed. Pet. Ex. 4.

50. On November 25, 2013, RMF filed a complaint against Respondent with Petitioner, alleging unethical conduct in that Respondent "accept[ed] money from a client for work completed by others with no intent to pay those parties . . . ." Pet. Ex. 40; T. 50:11-51:20.

51. Upon receiving the RMF complaint, Petitioner's PSC solicited a response from Respondent. Respondent provided a response to Petitioner on or about December 10, 2013. Pet. Ex. 41. In that response, Respondent did not deny that he had failed to pay RMF money owed, and did not raise any complaints about the services RMF provided on the ECSU project. *Id.*; T. 52:13-18. In that response, Respondent wrote, "As a matter of law, I am not personally responsible for the debts of M3DG. This complaint is not about my abilities as an architect." Pet. Ex. 41.

52. On May 28, 2014, Petitioner Board issued an Order, based on the above Findings of Fact, requiring Respondent to pay a civil penalty of Five Hundred Dollars ($500.00) for his violation of N.C. Gen. Stat. § 83A-15(a)(1)a. Pet. Ex. 42; T. 55:4-56:17.

53. Upon receiving the May 28, 2014 Order, Respondent requested an administrative hearing. Based on that request, Petitioner filed a petition for a contested case hearing, and a Request for Designation of Administrative Law Judge. T. 56:16-57:2.

54. At hearing, Respondent explained that M3DG had used an accounting practice whereby all received funds were deposited into, and disbursed out of, a single account. T. 146:16-147:12. Respondent began noticing problems with this type of accounting practice in 2007, which was approximately 5 years before he dissolved M3DG. Despite becoming aware of the accounting problems in 2007, and despite being warned repeatedly by Petitioner to pay subcontractors properly, Respondent made no efforts to adjust the accounting methods to a project-based accounting system, which he recognized as the better way to manage M3DG's financials. *Id.*; T. 148:19-149:4.

CONCLUSIONS OF LAW

1. This matter is properly before the Office of Administrative Hearings ("OAH") as OAH has both personal and subject matter jurisdiction over this case. The parties were properly noticed for hearing. To the extent that the Findings of Fact contain Conclusions of Law, or that the Conclusions of Law are Findings of Fact, they should be so considered without regard to the given labels.

2. For purposes of the Petitioner's governing practice act, the "practice of architecture" is defined as:

> performing or offering to perform or holding oneself out as legally qualified to perform professional services in connection with the design, construction, enlargement or alteration of buildings, including consultations, investigations, evaluations, preliminary studies, the preparation of plans, specifications and contract documents, **administration of construction contracts and related services** or combination of services in connection with the design and construction of buildings, regardless of whether these services are performed in persons or as the directing head of an office or organization.

N.C. Gen. Stat. § 83A-1(7) (Emphasis Added). The administration of construction contracts includes ensuring that individuals are paid properly and timely. T. 47:2-6.

3. N.C. Gen. Stat. § 83A-15(a)(1)a provides that:

> The Board shall have the power to suspend or revoke a license or certificate of registration, to deny a license or certificate of registration, or to reprimand or levy a civil penalty not in excess of five hundred dollars ($500.00) per violation against any registrant who is found guilty of dishonest conduct, including but not limited to: the commission of any fraud, deceit or misrepresentation in any professional relationship with clients or other persons . . . .

4. The three-step process to determine if the Petitioner's disciplinary action has a rational basis, is as follows:

a. Is there adequate evidence to support the Petitioner's May 28, 2014 Order and Findings of Fact?
b. Do the Petitioner's expressed Finding(s) of Fact in the May 28, 2014 Order adequately support the Order's subsequent Conclusions of Law?
c. Do the expressed Findings and/or Conclusions adequately support the Petitioner's ultimate decision?

NC State Bar v. Talford, 356 N.C. 626, 634, 576 S.E.2d 305, 311 (2003). According to *Talford*, this three-step process must be applied separately to both the adjudicatory phase of Petitioner's order, and the dispositional phase of Petitioner 's order. *Id.*

5. At the contested case hearing, Mr. Boney opined that Respondent, as a licensed architect designated to be the responsible charge of M3DG, breached his fiduciary responsibilities to his client, and to his subcontractors when he failed to disburse money that was obligated to the subcontractors. T. 106:22-107:8. Mr. Boney

also opined that such breach of his fiduciary duty constituted dishonest conduct in violation of N.C. Gen. Stat. §83A-15(a)(1)a. *Id.*

6. The foregoing Findings of Fact showed that Respondent's dishonest conduct implicated the welfare of his client, ECSU. Because Respondent failed to pay RMF money owed, which Respondent had received from ECSU for RMF's services, RMF was forced to stop its work on behalf of ECSU's ongoing project for approximately two months. *See In re Suttles Surveying, P.A.*, No. COA 12-1350, 2013 N.C. App. LEXIS 464, 742 S.E.2d 574, 578-79 (2013) (contractual breaches that implicate public safety, health and welfare may be grounds for disciplinary action by occupational licensing boards).

7. Notably, other jurisdictions have recognized that a contractor's failure to pay a subcontractor, in the absence of a good-faith dispute regarding the amounts owed, is grounds for disciplinary action. *See, e.g.* CAL. BUS. & PROF. CODE § 7108.5 (failure of contractor to pay subcontractor within 7 days of receipt of payment for subcontractor's services is grounds for discipline) (2014); NEV. REV. ADMIN. CODE § 624.3012 (2014) (grounds for disciplinary action exist upon "willful or deliberate failure by any licensee . . . thereof to pay any money when due for . . . services rendered in connection with the licensee's operations as a contractor, when the licensee . . . has received sufficient money therefore as payment for the particular . . . project or operation for which the services or materials were rendered . . . .") Although N.C. Gen. Stat. §83A-15(a)(1)a does not expressly define dishonest conduct to include the failure to pay a subcontractor, in the absence of a good-faith dispute regarding the amounts owed, it is reasonable to interpret the definition to include such acts.

8. Based on the foregoing Findings of Fact and Conclusions of Law, the undersigned concludes that Respondent violated N.C. Gen. Stat. § 83A-15(a)(1)a when he engaged in dishonest conduct by failing to pay a subcontractor monies owed, after the client had paid said monies to Respondent for that purpose.

9. Moreover, the undersigned concludes that the discipline assessed by the Board against Respondent for his violation of N.C. Gen. Stat. § 83A-15(a)(1)a is justified by the expressed Findings of Fact and Conclusions of Law set forth in the Petitioner's Decision and in this Proposal for Decision.

PROPOSAL FOR DECISION

Based on the Findings Of Fact and Conclusions Of Law, the undersigned recommends that Petitioner Board order Respondent to pay a civil penalty in the amount of Five Hundred Dollars ($500.00) within 30 days of this Proposal for Decision.

NOTICE

The North Carolina Board of Architecture will make the Final Decision in these contested cases, pursuant to N.C. Gen. Stat. § 150B-42. That agency is required to

give each party an opportunity to file exceptions to this Proposal for Decision and to present written arguments to those in the agency who will make the Final Decision, in accordance with N.C.G.S.§ 150B-36(a). The Board shall file a copy of its Final Decision on the parties and the Office of Administrative Hearings.

This 3rd day of March, 2015.

Melissa Owens Lassiter
Administrative Law Judge

NORTH CAROLINA		**OFFICE OF ADMINISTRATIVE HEARINGS**
BLADEN COUNTY		**14 CPS 6019**
JACK NORRIS	)	
	)	
Petitioner	)	
	)	
v	)	**FINAL DECISION**
	)	
NORTH CAROLINA VICTIMS COMPENSATION COMMISSION	)	
	)	
Respondent	)	

This matter coming on to be heard and being heard on February 9, 2015, and it appearing to the undersigned that the Petitioner appeared in this matter *pro se* and the Respondent was represented by Assistant Attorney General Yvonne B. Ricci, and based upon the evidence presented and the arguments of the parties, the undersigned by the greater weight of the evidence, makes the following findings of fact:

1. Petitioner is a citizen and resident of Bladen County, North Carolina.

2. Respondent is the Division of Victim Compensation Services within the North Carolina Department of Public Safety. Respondent is created under Chapter 15B of the North Carolina General Statutes and charged with administering the Crime Victims Compensation Fund in North Carolina.

3. Petitioner filed a Petition for a Contested Case Hearing on August 18, 2014 stemming from a denial by Respondent of his claim for compensation for injuries sustained in an assault.

4. On January 9, 2014, the Petitioner observed a Ford SUV truck on his more than seventy-five acre hog farm on CCC road in Bladen County that was pulling a trailer loaded with tin and scrap metal.

5. Petitioner testified that he observed the vehicle with two male occupants for more approximately one hour and fifteen minutes, and their behavior raised his suspicions because of criminal activity which had recently occurred at his property.

6. Petitioner was tending to business on his farm when he noticed the Ford SUV.

7. Petitioner initially saw the vehicle stationary on the side of the road. Petitioner walked towards the vehicle, and the vehicle then pulled back on the roadway and drove off. Petitioner witnessed this pattern several times over the course of approximately one hour and fifteen minutes.

8. Petitioner had recently done renovations and had metal still remaining on his property.

9. Petitioner also had approximately 50 hogs stolen from his property in the months leading up to this incident.

10. Petitioner went to his home to get medicine for his animals.

11. While in the home, Petitioner saw the Ford SUV again.

12. Petitioner pulled up alongside the passenger side of the Ford SUV while it was stationary.

13. Petitioner rolled down his window and asked the passenger, Gary Jones, if he [Mr. Norris] could help him.

14. The passenger told Mr. Norris that they could not get the vehicle out of four-wheel drive.

15. Mr. Norris then commented "are you sure that you are not trying to case out the place."

16. As the Petitioner was attempting to leave, the driver of the Ford SUV, a Timothy McLean, responded, "What God-damned business is it of yours?"

17. Petitioner stopped his vehicle, opened the door, and replied that if they were attempting to steal property that it was his business.

18. McLean told the Petitioner that he would assault, and said that Mr. Norris should leave the area because the property did not belong to him.

19. McLean told the Petitioner again to get back in his truck or he would assault him.

20. Petitioner made a comment to McLean that could not reasonably be considered a threat or fighting words, but McLean then ran towards Mr. Norris and began taunting him.

21. Mr. Norris asked McLean to stop taunting him.

22. McLean then grabbed the Petitioner, lifted him up, and took him to the ground.

23. McLean landed on top of the Petitioner.

24. Petitioner had the breath knocked out of him and could not get up.

25. Petitioner attempted to get up, but McLean pushed him back to the ground.

26. Petitioner grabbed McLean in an effort to protect himself from the assault.

27. McLean assaulted the Petitioner, hitting him multiple times in and about the face.

28. McLean then pushed the Petitioner's face against the gravel and broken pavement on the ground and then left the scene.

29. Upon leaving, a tire on the trailer of the Ford SUV brushed against the Petitioner's neck while he was still on the ground.

30. As a result of the assault, Petitioner suffered personal injury

31. Petitioner got into his vehicle and followed the Ford SUV.

32. Petitioner called 911 to report what had just occurred. A description of the vehicle was provided.

33. Respondent's evidence demonstrated that McLean struck the Petitioner first.

34. There was no evidence that Mr. Norris assaulted McLean, other than grabbing at him in an effort to stop the assault.

35. Mr. Norris was not the aggressor in the assault.

36. Elizabethtown Police Department Officer Roger T. Davis observed a vehicle entering Elizabethtown city limits which matched that description provided by 911 communications.

37. Officer Davis initiated a traffic stop with the Ford SUV.

38. Petitioner observed the traffic stop and pulled in behind Officer Davis' vehicle.

39. Officer Davis testified that the Petitioner's eye was swollen shut. Davis advised the Petitioner to seek medical attention at the hospital.

40. Sergeant Gregory N. Bullard with the Bladen County Sheriff's Department investigated the incident involving the Petitioner. Sgt. Bullard spoke with the driver of the SUV during the traffic stop initiated by Officer Davis.

41. Sgt. Bullard also spoke with the Petitioner in the emergency room at Bladen County Hospital.

42. No law enforcement officer observed any injuries to McLean, and there was no evidence that McLean suffered any injury.

43. Bullard advised both the Petitioner and the driver of the SUV that they could take out warrants.

44. Petitioner went to the magistrate to swear out a warrant, and a warrant was issued against McLean. That case was still pending at the time of this hearing.

45. Petitioner fully cooperated with law enforcement in the investigation and prosecution of this matter.

46. Petitioner was not charged with a crime and there is no evidence that the Petitioner engaged in any criminal conduct January 9, 2014.

47. Petitioner timely submitted a claim to the North Carolina Victims Compensation Commission for the cost of medical treatment stemming from this incident.

48. The parties stipulated that the Petitioner's medical bills for the purposes of this action were $4,691.55.

49. Liddie Shropshire, Respondent's Senior Claims Investigator, was assigned to investigate Petitioner's claim.

50. Investigator Shropshire interviewed a captain with the Bladen County Sheriff's Department about this incident. There was no evidence that the captain interviewed was actively involved in the on-scene investigation, only that he had reviewed documents relating to the January 9, 2014 incident.

51. Investigator Shropshire never spoke with the Petitioner in her investigation, as is the general practice in such investigations.

52. Investigator Shropshire never spoke with McLean in her investigation, as is the general practice in such investigations.

53. Investigator Shropshire did not speak with anyone directly involved in this matter, or the investigation thereof.

54. Investigator Shropshire relied solely on written reports of law enforcement in making her recommendation in this matter.

55. Investigator Shorpshire recommended that Petitioner's "claim be denied due to contributory misconduct and participating in a non-traffic misdemeanor at or about the time the victim's injury occurred."

56. Investigator Shropshire testified that her recommendation was specifically based on her findings that both the Petitioner and McLean were involved in an escalating altercation or mutual affray. Further, Investigator Shropshire indicated that in her opinion the Petitioner approached Mr. McLean referring to the last page of the Bladen County Sheriff's Office Incident/Investigation Report as follows: "Jack Norris stated that: I was on CCC Rd on one of my farm's when I saw a truck loaded down with metal going down the road. The truck stopped several times. I thought it was suspicious so I wrote the tag down. The truck pulled of the road a couple more times so I pulled up and asked the guy what he was doing. The driver said he was trying to put the truck in four wheel drive. I told the driver that he was trying to case out metal."

57. By a letter mailed to Petitioner on June 18, 2014, Respondent denied Petitioner's claim for compensation based upon (1) Petitioner's participation in a non-traffic misdemeanor, pursuant to N.C. Gen. Stat. § 15B-11(b)(1) and (2) contributory misconduct, pursuant to N.C. Gen. Stat. § 15B-11(b)(2).

58. Petitioner has no collateral source for compensation in this matter.

59. None of the disqualifying criteria in N.C. Gen. Stat. §15B-11 operate as a bar to Petitioner's claim.

Based upon the foregoing findings of fact, the undersigned concludes the following as a matter of law:

1. The Office of Administrative Hearings has jurisdiction over the parties and the subject matter herein.

2. Petitioner timely filed this Petition for a Contested Case Hearing.

3. Respondent has the authority and responsibility under Chapter 15B of the North Carolina General Statutes to investigate and award or deny claims for compensation under the Crime Victims Compensation Act.

4. N.C. Gen. Stat. § 15B-4(a) provides that "compensation for criminally injurious conduct shall be awarded to a claimant if substantial evidence establishes that the requirements for an award have been met."

5. Petitioner, as a victim of the assault on January 9, 2014, is a claimant pursuant to N.C. Gen. Stat. §15B-2(2).

6. As the victim of the assault, Petitioner suffered personal injury.

7. An assault in North Carolina is punishable by a fine and/or imprisonment.

8. Substantial evidence exists that the Petitioner suffered criminally injurious conduct in the January 9, 2014 incident pursuant to N.C. Gen. Stat. §15B-2(5).

9. Substantial evidence exists that none of the disqualifying criteria in N.C. Gen. Stat. §15B-11 operate to bar to Petitioner's claim.

10. While an assault is a "nontraffic misdemeanor," there is no evidence that the Petitioner assaulted McLean. To the contrary, the Petitioner was the victim of an assault who grabbed the perpetrator in an effort to stop the attack.

11. Petitioner is lawfully entitled to defend himself against an attack perpetrated by an aggressor.

12. Petitioner was not the aggressor in this incident.

13. McLean, the perpetrator of the assault, was the aggressor in this incident.

14. In determining whether Petitioner's claim was properly barred based upon contributory misconduct, "[t]he test . . . is two-pronged, that is, 1) was there misconduct on the part of [the victim] and, if so, 2) was that misconduct a proximate cause of his injury?" *McCrimmon v. Crime Victims Comp. Comm'n*, 121 N.C. App. 144, 148, 465 S.E.2d 28, 31 (1995).

15. "Misconduct is defined as . . . '[a] transgression of some established and definite rule of action, a forbidden act, a dereliction from duty, unlawful behavior, willful in character, improper or wrong behavior.' While misconduct includes unlawful conduct as a matter of law, it may be something less than unlawful conduct, though more than an act done in poor taste. Misconduct requires some deviation from the accepted norm or standard of proper behavior. Accordingly, the conduct of the claimant is misconduct if it is not within the accepted norm or standard of proper behavior, which includes unlawful conduct. Consistent with principles of tort law, the test for determining accepted norms and proper behavior is best determined by use of a reasonable man standard or what a reasonable person would have done under similar and like circumstances." *Evans v. N.C. Dep't of Crime Control & Pub. Safety*, 101 N.C. App. 108, 117-18, 398 S.E.2d 880, 885 (1990) (quoting Black's Law Dictionary 901 (5th ed. 1979)).

16. For a victim's misconduct to constitute "contributory misconduct" for purposes of N.C. Gen. Stat. § 15B-11(b)(2), the misconduct "must combine with criminal action on the part of another to become a real, efficient and proximate cause of the injury. . . . This Court has defined proximate cause as a cause which in natural and continuous sequence, unbroken by any new and independent cause, produced the plaintiff's injuries, and without which the injuries would not have occurred, and one from which a person of ordinary prudence could have reasonably foreseen that such a result, or consequences of a generally injurious nature, was probable under all the facts as they existed. The test of foreseeability as an element of proximate cause does not require that the actor should have been able to foresee the injury in the precise manner in which it actually occurred. Neither does the actor need to foresee the events which are merely possible, but only those which are reasonably foreseeable. Therefore, where a claimant's injuries are a direct result of the criminally injurious conduct of another, the claimant's own

misconduct must have been a proximate cause of those injuries in order for the Commission to deny or reduce a claim under the statute." *Id.* at 117, 398 S.E.2d at 885.

17. Petitioner observed a vehicle on and around his property for approximately one hour and fifteen minutes. That vehicle had scrap metal in a trailer, and the Petitioner recently had been the victim of theft. Petitioner approached the vehicle and initially asked if the occupants needed assistance; when they responded in the negative, Petitioner merely commented on the appearance of the conduct he observed that day. Petitioner's actions cannot reasonably be considered as a deviation from proper behavior or engaging in a forbidden act.

18. In fact, and quite to the contrary, Petitioner was being a vigilant citizen and landowner, seeking to determine what was taking place on and around his property, something done by reasonable citizens and landowners.

19. A reasonable person under similar circumstances would have inquired about what was taking place on and around his property.

20. While Petitioner could have called law enforcement at any time upon seeing the suspicious activity, he was not required to, nor was he under any duty to do the same.

21. Even if the Petitioner's actions were to be considered "misconduct," which they are not, Petitioner's conduct was not the proximate cause of his injury.

22. McLean's actions of exiting his vehicle, throwing the Petitioner to the ground, and assaulting him repeatedly was not a likely outcome of the Petitioner's initial encounter. A person of ordinary prudence could not reasonably foresee that Petitioner's conduct would yield such a result.

23. Respondent's denial of Petitioner's claim is not supported by the evidence presented at the hearing of this matter.

24. Respondent has substantially prejudiced Petitioner's rights.

25. Respondent's denial of Petitioner's claim was not based on a reasoned decision and was not made after careful consideration.

26. Respondent failed to act as required by rule or law in denying Petitioner's claim.

27. Respondent acted arbitrarily and capriciously in denying Petitioner's claim.

28. Respondent acted erroneously in denying Petitioner's claim.

DECISION

Petitioner's claim for relief is hereby granted. The Respondent shall pay $4,691.55 to Petitioner for medical bills associated with his treatment from the January 9, 2014 incident herein, and the Respondent shall be responsible for the costs of this action.

NOTICE

This is a Final Decision issued under the authority of N.C. Gen. Stat. § 150B-34.

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 of the county where the person aggrieved by the administrative decision resides, or in the case of a person residing outside the State, in the county where the contested case which resulted in the final decision was filed. **The appealing party must file the petition within thirty (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, North Carolina General Statute 1A-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.** 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 thirty (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.

IT IS SO ORDERED.

This the 30th day of March, 2015.

Philip E. Berger, Jr.
Administrative Law Judge

STATE OF NORTH CAROLINA	**THE OFFICE OF ADMINISTRATIVE HEARINGS**
COUNTY OF WAKE	**14 DHR 1503**

SUNRISE CLINICAL ASSOCIATES, PLLC,

Petitioner,

v.

ALLIANCE BEHAVIORAL HEALTHCARE, ***as legally authorized contractor of and agent for*** **N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES,**

Respondent.

FINAL DECISION

THIS MATTER came on for hearing before the undersigned, Donald W. Overby, Administrative Law Judge, on December 11, 2014, in Raleigh, North Carolina.

APPEARANCES

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

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

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

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

APPLICABLE LAW

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

BURDEN OF PROOF

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

ISSUES

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

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

ADMITTED EXHIBITS

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

1. Contract between Alliance and DHHS (Contract #207-013)
2. Contract between Alliance and DHHS Division of Medical Assistance (Contract #28172)
3. Alliance's Provider Manual
4. Alliance's Operational Procedure #6023 - Request for Information/Request for proposal
5. Alliance's Operational Procedure # 6012 -- Provider Network Capacity and Network Development procedure
6. Alliance's RFP for IIH
7. Alliance's RFP for CST
8. Alliance's RFP for SAIOP
9. Alliance's RFP Selection Summary
10. Alliance's RFP PowerPoint
11. 2014 Contract between Alliance and B and D Behavioral for RFP Services through June 30, 2014 (example of a contract given to providers who scored between 55 and 65 on interview)
12. 2014 Contract between Alliance and Carolina Outreach for RFP Services through December 31, 2014 (example of a contract given to providers who scored 65 and above on interview)

Joint Exhibits For Judicial Notice

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

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

Petitioner's Exhibit For Judicial Notice

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

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

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

12. Interview notes by Melissa Simpson

15. Affidavit by Melissa Simpson
20. 2014 Contract with Petitioner for non-RFP services

21. April 1, 2014 Contract Amendment with Petitioner following Preliminary

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

Carolina Community Petitioner Exhibits:

1. Carolina Community RFP Review Summary
2. Alliance RFP Interview Questions with Written Summaries of Responses
3. Contract Between NC Department of Health and Human Services and Alliance
4. Contract Between the NC Department of Health and Human Services, Division of Medical Assistance and Alliance
5. Carolina Community Provider Interview Sign-In Sheet
7. Carolina Community Gold Star Monitoring Results
8. Alliance RFP Desk Review Scoring Tool for Carolina Community
10. Alliance Request for Proposal, Community Support Team
11. Alliance Request for Proposal, Intensive In-Home Services
12. Alliance Power Point Presentation for Alliance's RFP Committee Training, November 15, 2013
13. Alliance RFP Selection Summary
16. Alliance Behavioral Healthcare Provider Operations Manual
19. Carolina Community Intensive In-Home RFP Response
20. Carolina Community SAIOP RFP Response
21. Carolina Community Team RFP Response
27. Alliance Operational Procedure #6023 – Request for Information/Request for Proposal (Rev. 8/26/13)
28. Alliance Operational Procedure #6012 – Provider Network Capacity and Network Development (Rev. 9/15/14)
29. NCDHHS Provider CABHA website, "CABHAs: Critical Access Behavioral Health Agencies"
30. Email dated 5/24/14 from MINT Operations Manual to Lamar Marshall regarding MINT training membership listings
31. Alliance Notice of Non-Renewal of Contract to Carolina Community dated November 12, 3014

Carolina Community Respondent Exhibits:

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

3. Alliance's RFP for SAIOP
4. Petitioner's Response to RFP for IIH
5. Petitioner's Response to RFP for CST
6. Petitioner's Response to RFP for SAIOP
7A. Desk Review Scoring Tool for Carolina Community for CST/SAIOP/IIH, reviewer Mary Ann Johnson (11/19/13)
8. Desk Review Scoring Tool for Carolina Community for CST, reviewer Alison Rieber (11/30/13)
9. 2013 Contract between Alliance and Petitioner
10. Three-month extension to 2013 Contract between Alliance and Petitioner (through 3/31/14)
11. Non-renewal letter from Alliance to Petitioner dated January 10, 2014
12. Training PowerPoint for interview
13. Sign-in sheets for Carolina Community interview
14. Interview notes by Cathy Estes
15. Interview notes by Damali Alston
16. Interview notes by Alison Rieber
17. Interview notes by Mary Ann Johnson
18. Affidavit of Cathy Estes
19. Affidavit of Damali Alston
20. Affidavit of Alison Rieber
21. Affidavit of Carlyle Johnson, with exhibits
22. Provider RFP Review Summary
23. 2014 Contract with Petitioner for non-RFP services
24. 2014 Contract with B and D Behavioral for RFP services through June 30, 2014 (example of a contract given to providers who scored between 55 and 65 on interview)
25. 2014 Contract with Carolina Outreach for RFP services through December 31, 2014 (example of a contract given to providers who scored 65 and above on interview)
26. April 1, 2014 Contract Amendment with Petitioner following Preliminary Injunction Order
27. Contract between Alliance and DHHS
28. Alliance's Provider Manual
29A. Contract Amendment between Alliance and Evergreen Behavioral Management
29B. Contract Amendment between Alliance and Fidelity Community Support Group
29C. Contract Amendment between Alliance and Sunrise Clinical Associates

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

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

Carolina Community Respondent Exhibits:

1.	Alliance's RFP for IIH
2.	Alliance's RFP for CST
3.	Alliance's RFP for SAIOP
4.	Petitioner's Response to RFP for IIH
5.	Petitioner's Response to RFP for CST
6.	Petitioner's Response to RFP for SAIOP
7A.	Desk Review Scoring Tool for Carolina Community for CST/SAIOP/IIH, reviewer Mary Ann Johnson (11/19/13)
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

7

WITNESSES

Petitioner presented the testimony of:

1. Anya Odim, Owner Sunrise Clinical Associates

Respondent presented the testimony of:

1. Melissa Simpson, Employee, Alliance Behavioral Healthcare

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

Petitioner:

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

Respondent:

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

PROCEDURAL HISTORY

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

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

This matter came on for full hearing before the undersigned on December 11, 2014.

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

FINDINGS OF FACT

The Parties

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

2. Sunrise was founded in 2007 and is a provider of Medicaid Intensive In-Home ("IIH") services and Community Support Team ("CST") services in the Alliance service area. (Pet. Ex. 1, p. 3; Odim, Vol. 1, pp. 167, 223). These services are Medicaid programs. (Johnson, Vol. 1, pp. 194–95).

3. Sunrise is also a Critical Access Behavioral Health Agency ("CABHA") certified by the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services ("DMH") and the Division of Medical Assistance ("DMA"). (Simpson, Vol. 1, pp. 56–57; Odim, Vol. 1, p. 225). Sunrise must provide CST or IIH services to continue to qualify as a CABHA. (Simpson, Vol. 1, p. 136; Odim, Vol. 1, p. 225; Johnson, Vol. 1, p. 186–87).

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

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

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

7. In February 2013, Alliance entered into two contracts with DHHS allowing it to serve as a managed care organization ("MCO") under the 1915(b)/(c) Medicaid Program. Alliance manages Medicaid mental health, developmental disability, and substance abuse services provided in Cumberland, Durham, Johnston, and Wake Counties. (Jt. Ex. 3, p. 9). Alliance's duties include authorizing and paying for recipient services, contracting with providers, and monitoring providers for compliance with regulatory and quality standards. (*Id.*, pp. 28–29, 138).

Federal, State, and Alliance Policy Requirements

8. The federal government has promulgated regulations that apply when states receive a waiver to operate Medicaid MCOs and PIHPs. One of these regulations is 42 C.F.R. § 438.214(a) entitled, "*Provider Selection.*" This regulation requires the State to ensure, through a contract, that each MCO/PIHP "implements written policies and procedures for selection and retention of providers." (Jt. Ex. 17) (Emphasis added).

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

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

11. In conformity with 42 C.F.R. § 438.214, Alliance has executed two contracts with DHHS. These contracts require Alliance to create Provider Selection and Retention policies. (Jt. Exs. 1, 2). One of the contracts states that, in determining whether CABHAs will remain in the MCO's network, the MCO must consider the "performance of the agency as measured against identified indicators and benchmarks." (Jt. Ex. 2, p. 92, Attachment O, Sec. 4).

12. The contract also anticipates that Alliance may issue RFPs, but states that "if there is a competitive Request for Proposal, a scoring process will be developed to assess the provider's

competencies specific to the requirements of the Request for Proposal, the service definition, and enrollment requirements as delineated above." (Jt. Ex. 2, p. 94, Attachment O).

13. Pursuant to federal law and the State contracts Alliance has developed provider selection and retention policies, which are included in the Alliance Provider Operations Manual. (Jt. Ex. 3, pp. 35–38; Johnson, Vol. 1, p. 180).

14. In instances where Alliance decides to use an RFP to select or retain providers, it has created an RFP Procedure that sets forth the process that Alliance will use in selecting providers. The purpose of these procedures "is to ensure that Alliance Behavioral Healthcare has a fair, uniform and consistent approach for establishing contracts with potential, new and current providers." (Jt. Ex. 4, p. 1).

The Alliance RFP

15. On September 30, 2013, Alliance announced that all current network providers of IIH, CST, and SAIOP would be required to respond to a Request for Proposal ("RFP") in order to continue to provide services in the Alliance Network. (Pet. Ex. 16, p. 7). Only existing providers were allowed to submit a response and the RFP was closed to providers who were not currently operating in the Alliance network. (Johnson, Vol. 1, p. 28).

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

17. One of the reasons Alliance issued the RFP was concerns it had over the quality of care being provided. (Johnson, Vol. 1, p. 172–73). However, Alliance did no review of the quality of services that had actually been provided by the providers who submitted an RFP response. (*Id.*). Rhetorically, if Alliance was truly concerned about quality of care, there were many other more efficient options for dealing with those providing sub-standard care, including the state mandated Gold-Star Monitoring assessments, which had already been completed in part.

18. Alliance released a separate RFP for each of the services. However, the contents of the RFPs were almost identical. (Johnson, Vol. 1, pp. 29–30; *compare* Jt. Ex. 6 *with* Jt. Ex. 7, and Jt. Ex. 8). The RFP process consisted of four steps. Alliance's articulated end goal was the identification and selection of an appropriate number of providers who can provide high quality, evidence-based and effective services for consumers in Alliance's four-county catchment area.

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

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

21. Sunrise was offered a three-month contract, and it accepted and signed a contract with an ending date of March 31, 2014. (Respondent's Exhibit 6). The three-month contracts offered by Alliance, including the one with Sunrise, contained no right to renewal or extension.

22. The RFPs included a number of service preferences that may be considered by Alliance during the review. (Jt. Exs. 6–8, p. 2). These preferences included:

- Demonstrated capacity to implement the requirements specified in the Scope of Work in this RFP;
- Have a solvent and financially viable organization with a history of financial stability that has sufficient financial and administrative resources to implement and operate the services specified in this RFP;
- Have a history of serving a monthly average of at least 6 per team in Intensive In-Home, 15 recipients for Community Support Team, and 15 recipients for SAIOP. Although caseload size is not a determining factor, organizations must demonstrate experience, financial viability, and the ability to provide the service in accordance with the service definition and the criteria in this RFP;
- History of submitting timely and complete requests for prior authorization that contain all administrative and clinical requirements (i.e. does not have an excessive number of administrative denials);
- Demonstrated ability to timely and successfully submit clean claims using the Alpha provider portal or 837s;
- Have a well-developed quality management program that monitors and improves access, quality, and efficiency of care;
- Have human resources and management support necessary to effectively recruit and retain clinical and administrative qualified professional staff.

(Jt. Exs. 6–8, p. 2).

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

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

(Jt. Exs. 6–8, p. 5).

24. Other than the preferences contained on page 2 of the RFP and the bullets points listed above, the RFP contained no other guidance or standards for determining if a provider would be retained or terminated from participation. (Jt. Exs. 6–8).

25. The RFP also requested that each provider include three references. The RFP indicates that references would be checked to "verify the accuracy of submitted materials and to ascertain the quality of past performance." (Jt. Ex. 6, p. 11; Jt. Ex. 7, 8, p. 12) Alliance did not use the references in any way during the review. (Johnson, Vol. 2, p. 338).

Alliance's Training of Staff that Conducted RFP Reviews

26. On November 5, 2013, Alliance held a training session for all staff members that would participate in the Desk Review or Interview process. (Johnson, Vol. 1, pp. 40–42; Pet. Ex. 16, p. 1).

27. As part of this training, Alliance created a 14-page PowerPoint presentation. (Pet. Ex. 16; Johnson, Vol. 1, p. 216). The first 12 pages of the PowerPoint contain no information directing reviewers on how to judge or score a provider's RFPs during the Desk Review or Interview. (Simpson, Vol. 1, pp. 128, 151; CC. Estes, Vol. 1, p. 105; Johnson, T. Vol. 1, pp. 217–20; Pet. Ex. 16).

28. Page 13 is the only page in the entire PowerPoint that contains any guidance on how the reviewers should assign scores during the Desk Review and Interview. Page 13 contains a Likert Rating Scale that ranges from 1 to 5. (Pet. Ex. 16, p. 13). The scale contains general descriptive terms for the 1–5 scores. For example, a score of 1 is "unsatisfactory, unclear and incomplete, insufficient;" a score of 3 is "sufficient and satisfactory but some questions or concerns;" and a score of 5 is "exceptional model program, no questions remain." Page 13 contains no guidance on how these scores should be assigned and does not outline the criteria that should be considered when assigning these scores. (*Id.*).

29. Alliance testified that the PowerPoint and the RFP were the only guidance reviewers were given to determine how to score a provider's response during the Desk Review and Interview. (Simpson, Vol. 1, pp. 128, 151; Johnson, Vol. 1, pp. 226-227; C.C. Alston, Vol. 2, p. 501). During the interview stage, the reviewers did not have a copy of the RFP when it assigned scores and did not compare the Sunrise's responses to the requirements, preferences or information requested in the RFP. (Simpson, Vol. 1, pp. 72, 128).

30. The RFP contained no information or guidance to reviewers indicating how the Likert Scores of 1–5 should be assigned. (Jt. Ex. 6–8). The only substantive guidance contained in the RFP are the preferences and the six Scope of Work requirements. (Jt. Exs. 1–3, pp. 2, 5). There was no guidance instructing reviewers on how these preferences or Scope of Work requirements should affect the score awarded to the provider during the Desk Review or Interview.

31. Many of the preferences Alliance listed in the RFP were not considered in the review at all or were not considered by the interview panel when assigning scores to providers. For example, Alliance did not consider its preference for providers that demonstrate timely submission of clean claims during the review. (Johnson, Vol. 2, pp. 321–22). Some of the RFP preferences were only considered during the Desk Review, while others were considered in both the Desk Review and the Interview. (*Id.*, pp. 326–27). There was no guidance given to the reviewers as to how to determine which preferences should be considered and what score should be assigned for meeting or not meeting these preferences. (Estes, Vol. 1, p. 105; Pet. Ex. 16; Jt. Exs. 6–8).

32. When asked by the Court if the reviewers had been given guidance on how to score providers, Allison Rieber, one of the individuals that participated in both the Desk Review and the Interview process stated – "there was not specific guidance." (Rieber, Vol. 2, p. 421). Similarly, Cathy Estes, another individual that participated in both the Desk Review and the Interview processes, testified that the training never included what an answer should look like, or what the requirements were. (Estes, Vol. 1, pp. 105–06, 115).

33. Instead, RFP reviewers were instructed to use their own experience and judgment when assigning scores. (Johnson, Vol. 1, p. 239). Alliance admitted that this standard was subjective in nature. (Simpson, Vol. 1, p. 154; Estes, Vol. 1, pp. 130, 151).

34. The lack of any standards led to many disparities over what information was relevant and responsive to the RFP and how that information should be scored. Reviewers trained through the exact same process and reviewing the exact same information scored responses very differently. In several instances a reviewer would determine a RFP response was inadequate and

unsatisfactory, while a different reviewer would find that same response good, strong, and clear. (Pet. Ex. 3, p. 4; Pet. Ex. 8, Chart of Scores).

35. The lack of any standards allowed reviewers to substitute their own preferences when no such preference existed in the Alliance RFP. For example, Alliance admitted that a reviewer or interview panel might believe that the provider should provide certain information regarding HIPAA compliance in response to a question, while another interview panel might believe that providing information regarding HIPAA compliance was unnecessary. (Rieber, Vol. 2, p. 423). Two Alliance employees testified that for CABHA medical directors the "preference is for psychiatrists." (Simpson, Vol. 1, pp. 19, 79; Johnson, Vol. 1, p. 252). No such preference is expressed by Alliance in its RFPs. (Jt. Exs. 6–8).

Sunrise's RFP Review

36. The Alliance RFP Review Process consisted of three steps once a provider submitted its written proposal. (Jt. Ex. 6, pp. 12–13; Johnson, Vol. 1, p. 32–34, 40). First, Alliance reviewed the written proposal to determine if the provider met minimum criteria. (Jt. Ex. 6, p. 12; Johnson, Vol. 1, p. 32). Both of Sunrises RFP Responses passed the minimum criteria requirements and proceeded to the Desk Review. (Pet. Ex. 1, p. 3).

The RFP Desk Review

37. The second step of the RFP process consisted of a Desk Review of the provider's written RFP Response. (Johnson, Vol. 1, p. 33). At the Desk Review stage, several individuals were assigned to review and score specific sections of the providers' written responses, which were given different weights when the Desk Review Score was assigned. (Johnson, Vol. 1, pp. 218–19). The RFP sections scored by Alliance in the Desk Review included: the Executive Summary (5%); Organizational Background (10%); Clinical Programming and Response to Scope of Work (50%); Legal and Compliance Information (10%); Financial Information (20%); and Technological Capability (5%). (Pet. Ex. 16, p. 10; Jt. Exs. 6–8, p. 13).

38. The review was conducted by various individuals employed by Alliance. For example, Alliance's legal department would review the legal and compliance information and Alliance's financial department would review the provider's financial information. (Johnson, Vol. 2, pp. 307–08). For the Clinical Programming Section of the Desk Review two individuals reviewed the written response and provided scores for each of seven categories. The scores for the seven categories were averaged to determine the Clinical Programming Score and Alliance used the highest average score as the provider's Clinical Programming score for the Desk Review. (Johnson, Vol. 1, p. 220).

39. If the provider scored 65% or higher on the Desk Review, the provider proceeded to the final stage of the RFP process. (Johnson, Vol. 1, pp. 33–34). At the Desk Review portion of the process, Sunrise received a score of 69.1% for the IIH review and 75.1% CST review. (Pet. Ex. 1, p. 3). Thus, Sunrise qualified for an interview for these services.

40. The evidence shows that the Desk Review scores for the Clinical Review portion of the Desk Review varied significantly depending on who conducted the review. In Sunrise's IIH Desk Review one clinical reviewer scored Questions 2 and 3 as a 4. (Pet. Ex. 4, pp. 2, 3). This

means that the reviewer felt that Sunrise's response was good, strong, well-planed and clear. (*Id.*). The other clinical review scored the same questions as a 2 and a 2.5. (Pet. Ex. 5, pp. 2, 3). This means that the reviewer felt the exact same response was minimal, weak, and confusing. (*Id.*).

41. The evidence demonstrates that this variation in the scoring was systemic. In Carolina Community's CST Desk Review, one reviewer, Allison Rieber, gave Carolina Community a score of 4 for Clinical Questions 2–4. (Pet. Ex. 8, Chart of Scores). The other reviewer, Cathy Estes, reviewing the exact same information gave Carolina Community a score of 2 for Clinical Question 2 and scores of 1 to Clinical Question 3–4. (Pet Ex. 8, Chart of Scores). For almost 50% of the clinical questions in Carolina Community's Desk Review, the reviewers had completely different understandings of what was required in the RFP. When Ms. Estes was asked about the difference in scores, Ms. Estes testified that this was the result of the fact that she and Ms. Rieber had "different backgrounds and experiences." (Estes, Vol. 1, p. 151).

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

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

The RFP Interview Process

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

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

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

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

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

49. As with the Desk Review, the interview panel used the Likert score of 1–5 for scoring these nine questions. (Pet. Ex. 16, p. 13; Simpson, Vol. 1, p. 29; Estes, Vol. 1, pp. 96–97). The interview panel was given the same training and guidance on how to score the provider's interview responses forth in Findings of Fact above. (Johnson, Vol. 1, pp. 40–42).

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

51. If a provider made it to the interview portion of the RFP process, the determination of whether that provider would be retained or terminated was made solely on the score assigned by the provider's interview panel. (Estes, Vol. 1, pp. 137–38; Johnson, Vol. 2, p. 314).

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

Sunrise's Interview Scores

53. Sunrise received a score of 52.2% for both its CST and IIH services. (Pet. Ex. 1, p. 3). Sunrise's final interview score was determined by the scores given by the interview panel in response to nine different questions that were asked during the interview. (Pet. Ex. 1, pp. 3, 4; Pet. Ex. 7).

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

55. After Sunrise was notified it would no longer be a provider, Alliance provided Sunrise with written justification for the scores it received in the interview process. If Sunrise received a score below 3 Alliance provided specific justifications for why that the score was

assigned. (Pet. Ex. 1, pp. 3–5). If a score of 3 or higher was assigned, Alliance did not provide any justification for the score. (*Id.*).

Question 1 – Organizational Strengths

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

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

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

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

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

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

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

Question 2 – Medication Management and Psychiatric Capacity

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

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

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

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

Question 3 –CABHA Medical Director and Clinical Oversight

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

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

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

Question 4 – Staffing for Services

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

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

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

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

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

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

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

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

Question 5 – Evidence-Based Practices and Measures Fidelity

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

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

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

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

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

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

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

84. For Question 7, *Service Capacity and Plans for Acceptance of Transitioned Consumers*, Sunrise also received a 3. (Pet. Ex. 1, p. 5). Sunrise provided a great deal of

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

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

Question 8 –Community Partnerships and Diversity of Population Served

86. Question 8 related to the providers community partnerships and diversity of the population served. Sunrise received a 3. (Pet. Ex. 7, p. 3). Again, Ms. Simpson could not recall why the committee gave Sunrise a 3 and not a 4 in this category. (Simpson, Vol. 1, p. 123–24). In response to the *Community Partnerships and Diversity of Population* category, Sunrise provided an extensive list of community agencies for which it has partnerships. (Odim, Vol. 1, pp. 209–210; Simpson, Vol. 1, pp. 121–122 Pet. Ex. 7, p. 3). Sunrise also provided a large number of diverse communities it serves, including the LGBT community, the Hispanic community, and HIV males and noted its use of translators. (*Id.*).

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

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

Question 9 – Quality Management

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

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

91. Based on the above Findings of Fact, the scores given to Sunrise in the interview portion of the RFP process are not supported by the justifications cited by Alliance. These justifications are erroneous, often unrelated to the RFP, do not demonstrate that Sunrise was not conforming with any statute, regulation, or clinical coverage policy, and are arbitrary and

capricious. Because Alliance's staff was not trained in the qualifications and requirements by the RFP, the interview panel simply substituted its own subjective judgment by assigning scores to Sunrise that were not related to the RFP requirements and preferences.

Federal Requirements for Retention of Providers

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

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

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

95. The federal government has promulgated regulations that apply when states receive a waiver of federal Medicaid law to operate Medicaid MCOs and PIHPs. One of these regulations is 42 C.F.R. § 438.214(a) entitled "*Provider Selection.*" This regulation requires the State to ensure, through a contract, that each MCO/PIHP "implements written policies and procedures for selection and retention of providers." (Jt. Ex. 17) (emphasis added). 42 C.F.R. § 438.214(e) requires MCO/PIHPs to "comply with any additional requirements established by the State."

96. 42 C.F.R. § 438.214 does not limit the selection and retention policies that can be implemented by an MCO/PIHP such as Alliance, but does require that these policies include at a minimum: (1) a process for credentialing and re-credentialing of providers who have signed contracts or participation agreements; (2) policies relating to nondiscrimination for providers that serve high-risk populations or costly treatment; and (3) a policy that the MCO/PIHP will exclude providers that are excluded by the federal health care program. *See* 42 C.F.R. § 438.214.

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

DHHS Contract Requirements Relating to Provider Retention

98. Pursuant to 42 C.F.R. § 438.214, Alliance has executed two contracts with DHHS that contain Provider Selection and Retention requirements. First, Alliance executed a contract with the Department of Health and Human Services, Division of Mental Health ("DMH"). The

DMH Contract requires Alliance to have written policies and procedures for "the determination of need, selection and retention of network providers." (Jt. Ex. 1, p. 23).

99. Alliance has also entered into a contract with the North Carolina Department of Health and Human Services, Division of Medical Assistance ("DMA"). The DMA Contract contains a similar provision requiring Alliance to create written policies and procedures for the selection and retention of network providers. (Jt. Ex. 2, pp. 32–33).

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

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

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

101. Under the DMA Contract, CABHAs are considered agency-based providers. (Pet. Ex. 4, p. 92, Contract Attachment O). The DMA Contract states that "maintenance of agency-based providers [such as CABHAs] depends on performance of the agency as measured against identified indicators and benchmarks as well as Alliance's need as identified in an annual assessment." (Jt. Ex 2, p. 92, Attachment O, Sec. 4). Thus, under Attachment O, whether CABHA is allowed to continue to provide services, must depend on the performance of the agency, specific measurable benchmarks and Alliances annual needs assessment.

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

103. The DMA Contract also required Alliance's decision to be based on "identified indicators and benchmarks." (Jt. Ex. 2, p. 4, p. 92, Attachment O, Sec. 4). Alliance did not base its decision on identified indicators and used no benchmarks during in the RFP process. Alliance violated the contract requirement based on the RFP review it conducted in this case.

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

Alliance Policies and Procedures Relating to Provider Retention

105. In conformity with federal law and the State contracts, Alliance has developed provider selection and retention policies, which are included in the Alliance Provider Operations Manual. (Jt. Ex. 3, pp. 35–38; Johnson, Vol. 1, p. 180).

106. Section K of the Provider Operations Manual sets forth Alliance's Selection Criteria for initial participation in the Alliance network and is not applicable here because Sunrise is already a provider in the Alliance network. (Jt. Ex. 3, p. 35).

107. Section L of the Provider Operations Manual sets forth Alliance's Retention Criteria (the "Retention Criteria"). Section L applies to decisions by Alliance relating to "contract renewal and reductions in network providers based on State and Federal laws, rules, regulations, DHHS contract requirements, the Network Development Plan, and the Alliance Selection and Retention Criteria." (Jt. Ex. 3, p. 36).

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

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

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

111. The Retention Criteria also states that Alliance "has the right to renew a contract with a Network Provider for any reason . . . in the sole discretion of Alliance." (Jt. Ex. 3. p. 37). Alliance cites this language from the policy as the basis for it having complete discretion to determine if a provider will be retained. (Res. Ex. 21, p. 6).

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

113. According to Dr. Johnson because Alliance operates a closed network, it has absolute discretion to determine with whom it wants to contract. (Johnson, Vol. 2, pp. 371–72). Alliance's contention of its position of authority as a "closed network" is demonstrated in part by the RFP which states that "Alliance reserves the right to reject any and all proposals for any reason,

. . ." Further, Alliance has said that in exercise of its discretion, it simply does not want to contract with Carolina Community.

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

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

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

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

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

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

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

120. One of the conditions in Alliance's provider retention policy for non-renewal is that Alliance issues an RFP or RFI. (*Id.*, p. 38). However, this policy does not state that if Alliance issues an RFP it can ignore its 17 provider retention factors when it creates the RFP review criteria.

Further, Alliance's contract with DMA specifically states that if an RFP is used, Alliance must use the clinical coverage policies and the other requirements for retention contained in the DMA contract. (Jt. Ex. 2, p. 94, Attachment O).

Alliance's RFP Procedures

121. In instances where Alliance decides to use an RFP process, it has created an RFP Procedure that sets forth the process that Alliance will use in selecting providers. Alliance expects its staff to follow the RFP procedure when conducting an RFP review. (Johnson, Vol. 1, p. 226). The purposes of these procedures "is to ensure that Alliance Behavioral Healthcare has a fair, uniform and consistent approach for establishing contracts with potential, new and current providers." (Jt. Ex. 4, p. 1). Alliance's RFP Policy sets forth instances when exceptions to the procedure can be made. None of those exceptions apply in this contested case. (*Id.*).

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

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

124. The RFP Procedure also requires Alliance to develop a RFP Scoring Sheet based upon Bidder Criteria and Response Requirements outlined in the RFP template. (Jt. Ex. 4, p. 2, Sec. 2.C.f). The evidence demonstrates that Alliance did not follow this procedure. The RFP scoring sheet and guidance given to Alliance reviewers only outlined a scoring range of 1–5 but did not contain Bidder Criteria or Response Requirements. (Pet. Ex. 12, p. 13).

125. Alliance's RFP Procedure further requires the Project Leader to gather relevant agency compliance, complaint, and performance history and disseminate it to the Selection Committee to use as part of the evaluation/review process. (Jt. Ex. 4. p. 2 Sec. D.3). Alliance failed to do provide its interview panels with any compliance history. (Johnson, Vol. 2, p. 339). As a result, the interview panels had no way of knowing if the provider's response about their program was confirmed or contradicted by their compliance history. In addition, the DMA Contract required Alliance to base its decision on the demonstrated performance of the agency. (Jt. Ex. 2, p. 94, Attachment O).

126. Specifically, as it relates to Sunrise, a review of its past compliance history would have been important. Alliance had conducted a thorough state-mandated review of Sunrise called

"Gold Star Monitoring" only a few months prior to the interview. (Pet. Ex. 23; Odim, Vol. 1, pp. 172–173)

127. Sunrise received a total score of 99% in this monitoring, with no score in any category below 97%. (Pet. Ex. 23). This score would constitute a very good score in this review. (Rieber, Vol. 2, p. 405). In contrast, over 40% of the reviewed providers received at least one score below 85% and required a plan of correction. (*Id.*, p. 402). Ms. Rieber, who confirmed that the results from the Gold Star monitoring would constitute provider compliance history. (Rieber, Vol. 2, p. 405). Under Alliance's RFP policy, the members of the Selection Committee should have been provided with information regarding Sunrise's Gold Star Monitoring Score. (Pet. Ex. 27; Jt. Ex. 4, p. 2, Sec. D.3).

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

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

130. Alliance's RFP procedure also requires that the Selection Committee should be "convened to evaluate and review all responses." In this RFP review, the Selection Committee was not convened to evaluate and review all responses. (Johnson, Vol. 2, pp. 308, 310, 330–31). Instead, if the provider made it to the interview stage, the decision was made solely by the provider's interview panel. (C.C. Estes, Vol. 1, pp. 137–38; Johnson, Vol. 2, pp. 313–14).

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

Provider's Selected by the RFP Process

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

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

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

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

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

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

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

CONCLUSIONS OF LAW

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

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

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

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

4. This contested case is not merely a contract case as Alliance contends. This contested case is about Alliance's almost total disregard for Federal and State laws and regulations and its own policies. Based on the evidence, the process for the RFP seems almost like it began on a whim—ostensibly to fix problems that had no basis in fact. The result was a flawed RFP in which providers which might otherwise be comparable were treated differently, based in significant part on a subjective review.

5. Under numerous Supreme Court holdings, most notably the Court's holding in *Board of Regents v. Roth*, 408 U.S. 564 (1972), the right to due process under the law only arises when a person has a property or liberty interest at stake. S*ee also Bowens v. N.C. Dep't of Human Res.*, 710 F.2d 1015, 1018 (4th Cir. 1983).

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

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

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

9. Under Chapter 108C, providers have a statutory expectation that a decision to terminate participation will not violate the standards of Article 3 of the APA. The enactment of Chapter 108C gives a provider a right to not be terminated in a manner that (1) violates applicable law or rule; (2) is in excess of the Department's authority or jurisdiction; (3) is erroneous; (4) is arbitrary and capricious; or (5) fails to use proper procedure. To conclude otherwise would nullify the General Assembly's will by disregarding the rights conferred on providers by Chapter 108C. This expectation cannot be diminished by a regulation promulgated by DMA, which states that provider's do not have a right to continued participation in the Medicaid program because, under the analysis in *Bowen*, the General Assembly created this right through statutory enactment.

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

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

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

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

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

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

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

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

> A Medicaid enrollee, or network provider authorized in writing to act on behalf of the enrollee, who appeals a notice of resolution issued by an LME/MCO under Chapter 108D of the General Statutes may commence a contested case under this Article in the same manner as any other petitioner. The case shall be conducted in the same manner as other contested cases under this Article. Solely and only for the purposes of contested cases commenced as Medicaid managed care enrollee appeals under Chapter 108D of the General Statutes, an LME/MCO is considered an agency as defined in G.S. 150B-2(1a). The LME/MCO shall not be considered an agency for any other purpose.
>
> N.C. Gen. Stat. § 150B-23 (a3)

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

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

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

21. 42 C.F.R. § 438.214 entitled "*Provider Selection*" requires the State to ensure, through a contract, that each MCO/PIHP "implements written policies and procedures for selection and retention of providers." (Jt. Ex. 17) (Emphasis added). Alliance admits that it is subject to this regulation.

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

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

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

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

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

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

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

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

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

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

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

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

34. The evidence in this case demonstrates that Alliance's interview scores were arbitrary and capricious because they indicate a clear lack of fair and careful consideration. The

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

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

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

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

DECISION

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

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

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

NOTICE

Under the provisions of North Carolina General Statute § 150B-45, any party wishing to appeal the final decision of the Administrative Law Judge must file a Petition for Judicial Review in the Superior Court where the person aggrieved by the administrative decision resides. The appealing party must file the petition within 30 days after being served with a written copy of the Administrative Law Judge's Final Decision. In conformity with the Office of Administrative Hearings' Rule, 26 N.C. Admin. Code 03.012, and the Rules of Civil Procedure, N.C. General Statute 1A-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 Apr. 2015.

Donald W. Overby
Administrative Law Judge

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. See *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

STATE OF NORTH CAROLINA	Filed	**THE OFFICE OF ADMINISTRATIVE HEARINGS**
COUNTY OF WAKE	2015 FEB 23 PM 3:15	**14 DHR 1594**
FIDELITY COMMUNITY SUPPORT GROUP, INC.,	Office of Administrative Hearings	
Petitioner,		
v.		
ALLIANCE BEHAVIORAL HEALTHCARE, ***as legally authorized contractor of and agent for*** **N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES,**		**AMENDED FINAL DECISION**
Respondent.		

THIS MATTER came on for hearing before the undersigned, Donald W. Overby, Administrative Law Judge, on December 10, 2014 in Raleigh, North Carolina. A Final Decision was issued by the Undersigned on April 2, 2015. This Revised Final Decision is intended to correct typographical errors in the second paragraph of the Decision Section, whereby the name Carolina Community was inadvertently used in place of Fidelity and on page 8 in the Findings of Fact, whereby the principal place of business of Petitioner Fidelity Community Support Group, Inc. was inadvertently identified as Raleigh, North Carolina when it should have been identified as Durham, North Carolina. The entire Final Decision is not set forth herein, and those portions not specifically set forth are not affected by this Amended Final Decision, and remain in full force and effect.

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.

FINDINGS OF FACT

1. Petitioner Fidelity is a provider of mental health and behavioral health services with its principal place of business in Durham, 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.

BURDEN OF PROOF

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

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 Fidelity 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 Fidelity should be allowed to continue to provide these services until such time as Alliance determines that Fidelity 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 03.0102, 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 enclosed in a wrapper addressed to the person to be served and placed in an official depository of the United States Postal Service, as evidenced by the postmark date of the wrapper.

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.

Entered, *nunc pro tunc*, the 2nd day of April 2015.

This Revised Final Decision signed and entered this the 28th day of April, 2015

Donald W. Overby
Administrative Law Judge