STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

COMPREHENSIVE MEDICAL ACCESS, INC.,	)	
Petitioner,	)	
vs.	)	Case No. 06-1502
OFFICE OF INSURANCE REGULATION,	)	
Respondent.	)	

RECOMMENDED ORDER

Pursuant to notice, a formal hearing was held in this case on July 18, 2006, in Tallahassee, Florida, before Patricia M. Hart, a duly-designated Administrative Law Judge of the Division of Administrative Hearings.

APPEARANCES

For Petitioner: Joseph S. Rosenbaum, Esquire
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For Respondent: Elenita Gomez, Esquire
S. Marc Herskovitz, Esquire
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STATEMENT OF THE ISSUE

Whether the Petitioner's application to offer a health flex plan pursuant to Section 408.909, Florida Statutes, should be granted or denied.

PRELIMINARY STATEMENT

On July 21, 2005, the Office of Insurance Regulation ("OIR") issued a Health Flex Entity letter of disapproval in which it notified Comprehensive Medical Access, Inc. ("Comprehensive Medical Access"), that its application for approval to participate in the "health flex entity program" was denied. The OIR further stated:

> The denial is based on the following reasons:
>
> Dr. Jack J. Michel owns and manages Comprehensive Medical Access. Dr. Michel, along with his brother, Dr. George Michel, have been named as defendants in a civil suit brought by the United States government, Case NO. 04-21579 CIV - Jordan/Brown filed on June 29, 2004, in the United States District Court, Southern District of Florida, United States of America, Plaintiff, vs. Jacobo Michel, M.D. etc. et al., Defendant. The allegations involve two alleged schemes to defraud the United States Government by submitting false and fraudulent claims to the Medicare and Medicaid programs. The first scheme (which allegedly took place between March 1997-December 1997) involved obtaining patient referrals to Larkin Community Hospital by paying kickbacks and illegal remuneration to physicians, and by entering into prohibited financial relationships with physicians, to induce such physicians to refer patients to

> Larkin. The bulk of the referrals involved alleged services that were not medically necessary.
>
> The second alleged scheme, which took place from January 1, 1998 (Dr. J. Michel purchased the hospital from Dr. James Desnick in April 1998), to at least December 31, 1999, involved fraudulently increasing the Larkin Community Hospital patient census and Medicare and Medicaid revenues by churning patients into Larkin from a variety of skilled nursing facilities and assisted living facilities (many of which Dr. J. Michel has ownership interest) for medically unnecessary services.
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> Pursuant to Section 408.909(3)(b), the Office shall disapprove any plan that cannot demonstrate that the applicant and its management are in compliance with the standards required under s. 624.404(3).
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> Section 624.404(3), Florida Statutes, provides that the Office shall not grant authority to any insurer whose management, officers or directors of which are found to be incompetent and untrustworthy; and the Office shall not grant authority to an insurer which it has good reason to believe is affiliated directly or indirectly through ownership, control, or other insurance or business relations, with any person or persons whose business operations are or have been marked, to the detriment of policyholders or the public, by manipulation of assets, accounts, or by bad faith.
>
> The plan has failed to demonstrate that the applicant and its management are in compliance with the standards required under s. 624.404(3). The plan therefore is disapproved.

The remainder of the letter consists of the Notice of Rights, in which Comprehensive Medical Access was notified of its right to

request a proceeding under Sections 120.569 and 120.57, Florida Statutes (2006).[1]

Comprehensive Medical Access timely requested an administrative hearing involving disputed issues of material fact, and the OIR transmitted the matter to the Division of Administrative Hearings for assignment of an administrative law judge. The matter was assigned DOAH Case No. 05-3963. The file of the Division of Administrative Hearings was closed in an order entered February 27, 2006, on the motion of Comprehensive Medical Access to refer the matter back to the OIR because Comprehensive Medical Access believed that the matter could be resolved without the need for a final hearing. On April 11, 2006, Comprehensive Medical Access filed a motion requesting that the Division of Administrative Hearings re-open the file in this matter because the parties had been unable to reach agreement on the terms of a settlement. The request was granted in an order entered May 2, 2006, and the Division of Administrative Hearings re-opened the matter and assigned it DOAH Case No. 06-1502. Pursuant to notice, the final hearing was held on July 18, 2006.

At the hearing, Joint Exhibits 1 through 3 were offered and received into evidence, and official recognition was taken of Sections 408.909 and 624.404, Florida Statutes. Joint Exhibit 1 is the application filed by Comprehensive Medical Access, and

Joint Exhibit 2 is a copy of the civil complaint filed by the United States against Dr. Jacobo Michel and others. In order to expedite the proceedings, facilitate the orderly presentation of evidence, and aid in narrowing the issues and because Comprehensive Medical Access's application was in evidence and was sufficient to establish its prima facie case, the OIR was asked to present any evidence in addition to the civil complaint admitted as Joint Exhibit 2 that it wished to offer in support of its position that Comprehensive Medical Access's request for approval to offer a health flex plan first should be denied. Although it objected to this order of presentation of evidence,[2] the OIR offered Respondent's Exhibits 1 through 5, which were received into evidence, but it did not offer the testimony of any witnesses; Respondent's Exhibit 1 is the transcript of an "Investigative Hearing" conducted by the OIR prior to issuing its notice of intent to deny Comprehensive Medical Access's application. Comprehensive Medical Access offered the testimony of Jack (Jacobo) Michel, M.D., Comprehensive Medical Access's owner and Chief Executive Officer; Petitioner's Exhibits 10 through 14 were offered and received into evidence; Petitioner's Exhibit 9 was offered into evidence but rejected. The parties indicated during the hearing that they intended to offer written proffers of evidence that had been excluded, and they agreed to

file the proffers with or prior to the filing of their proposed findings of fact.

The one-volume transcript of the proceedings was filed with the Division of Administrative Hearings on July 26, 2006. The parties filed a joint motion on August 4, 2006, in which they requested an extension of time until September 13, 2006, for filing their proposed findings of fact and conclusions of law and their written proffers; the extension was granted in an order entered August 7, 2006. Comprehensive Medical Access timely filed its proposed findings of fact and conclusions of law, which have been considered in the preparation of this Recommended Order. The OIR timely filed a post-hearing submittal which contained primarily argument relating to what it considers procedural defects in the administrative hearing and "Conclusions of Law."[3]

Proffers

Both parties took issue with the exclusion of certain evidence, and both submitted written proffers.

Comprehensive Medical Access

During the hearing, Comprehensive Medical Access sought to introduce evidence consisting of the results of a search of the "Company Directory" database of the official website of the Department of Financial Services showing that an insurance company doing business as Blue Cross Blue Shield of Illinois had

been licensed as a life and health insurer in Florida in June 2004, together with a listing of "Top False Claims Act Cases" drawn from the internet, purporting to show that, in July 1998, a company identified as "Blue Cross Blue Shield Illinois" had been assessed a criminal penalty and paid $140,000,000.00, apparently in settlement of a federal false claims act case. The evidence was excluded on the ground that it was not relevant to the issue of whether the OIR should grant or deny Comprehensive Medical Access's application.

Upon review of Comprehensive Medical Access's proffered exhibit and of the argument submitted in the written proffer regarding its relevancy to the question of whether Comprehensive Medical Access's application should be granted, it is determined that the proffered exhibit should not be received into evidence. The proffered documents do not establish that the situation of Comprehensive Medical Access is sufficiently similar to that of Blue Cross Blue Shield of Illinois to render the comparison relevant in determining whether Comprehensive Medical Access's application should be granted or denied. Even accepting that the information contained in the list of false claims act settlement amounts is accurate, Blue Cross Blue Shield of Illinois may have submitted sufficient information for the OIR to conclude that, notwithstanding its payment of a settlement and criminal penalty to the federal government, it was

trustworthy and fit to be licensed as an insurance company in Florida. Even when determining the appropriate penalty to assess for a particular statutory or rule violation, an area in which an agency's authority is more circumscribed than it is in determining whether to grant or deny an application for a license or permit, the cases offered for comparison must be substantially similar in all material respects to be helpful in determining the appropriate penalty to be imposed in the case under consideration. See Miami-Dade County Sch. Bd. v. Steven Newbold, DOAH Case No. 03-3217, 78-79 (Fla. Div. Adm. Hearings, Recommended Order, August 9, 2004). See also Department of Health, Board of Medicine v. Walter Inkyun Choung, M.D., Case No.05-3156PL, 15 (Fla. Div. Adm. Hearings, Recommended Order, January 20, 2006)("[A]ccess to the final orders introduced at hearing allows a comparison of punishment in prior cases, under their facts, to the present record to establish appropriate punishment here.").

OIR

The OIR called no witnesses to testify regarding the basis for its proposed denial of Comprehensive Medical Access's application. During cross-examination of Dr. Michel, however, the OIR asked him questions about matters going to the truth or falsity of the allegations contained in the civil complaint. Comprehensive Medical Access's counsel objected to these

questions on the ground that they exceeded the scope of direct examination, pointing out that no questions were asked of Dr. Michel regarding the truth or falsity of the allegations in the civil complaint during Comprehensive Medical Access's direct examination of Dr. Michel. Counsel for Comprehensive Medical Access noted that it was Comprehensive Medical Access's position that the filing of the civil complaint, the sole basis stated in the denial letter for the OIR's preliminary decision to deny Comprehensive Medical Access's application, is not evidence of lack of fitness or trustworthiness and that the truth or falsity of the allegations in the civil complaint were irrelevant in this proceeding.[4] Comprehensive Medical Access's objection to these questions were sustained, and the OIR was given leave to file a written proffer of the evidence it sought to elicit from Dr. Michel.[5]

Having considered the arguments set forth in the OIR's written proffer and the subject matter of the proffered questions, it is determined that the hearing should not be re-opened for the purpose of allowing the OIR to examine Dr. Michel with the questions included in the proffer. In support of its proffer, the OIR stated that it

> believes that the responses to these questions would have shown that Petitioner did in fact receive the payments alleged in the Civil Complaint, that Petitioner and his entitles were not in compliance with the

> Stark Law . . . ; that he was in fact in a position of responsibility and control when the alleged schemes took place, and that all of these things, coupled with the fact that as of the date of disapproval, the Office still did not have complete answers regarding the application requirements or the Civil Complaint, led the Office to determine that Petitioner did not meet the fitness and trustworthiness standards of the statute.

The OIR maintained both in its July 21, 2005, preliminary denial letter and consistently throughout this proceeding that the sole fact underlying its determination that Comprehensive Medical Access's application should be denied was the filing of the civil complaint by the United States Government, and, consistent with its theory of the case, Comprehensive Medical Access did not address the truth or falsity of the allegations during its direct examination of Dr. Michel. Thus, the questions submitted by the OIR were outside the scope of direct examination. In addition, given that the denial letter referenced only the filing of the civil complaint as the basis on which it determined that Dr. Michel was unfit and untrustworthy, the proof that OIR sought to establish by the questions identified in its proffer is irrelevant to its case in support of the basis for its proposed denial of Comprehensive Medical Access's application.[6]

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following findings of fact are made:

1. The OIR and the Agency for Health Care Administration each must "approve or disapprove health flex plans that provide health care coverage for eligible participants." § 408.909(3), Fla. Stat. The purpose of health flex plans is to provide basic and preventive health care services "to low-income uninsured state residents." § 408.909(1), Fla. Stat.[7]

2. On November 12, 2004, Comprehensive Medical Access submitted an application to the OIR for approval to participate in the health flex plan pilot program created by the Legislature in Section 408.909, Florida Statutes. Comprehensive Medical Access was formed in 2003 for the purpose of applying for approval to offer a health flex plan.

3. Jack J. Michel, M.D., wholly owns Comprehensive Medical Access, and is its president and chief executive officer. Dr. Michel specializes in the practice of internal medicine, and has been licensed to practice medicine in Florida since 1993. Dr. Michel owns ten healthcare-related companies.

4. In 1998, Dr. Michel purchased Larkin Community Hospital, which is located in South Miami, Florida, and he is the chief executive officer of the hospital in charge of running

the hospital. Larkin Community Hospital is a general acute-care hospital that provides surgery facilities and an emergency room. The hospital specializes in providing care to elderly patients, and has an annual operating budget of $30 to $40 million a year, with a monthly payroll of $1.4 million. Larkin is currently approved as a Medicare and Medicaid provider, and it also provides services under contract for federal and state prisoners. In addition, Larkin Hospital and Dr. Michel have been licensed by Florida and the federal government to provide home health services under Medicaid and Medicare.

5. Comprehensive Medical Access, under the management of Dr. Michel, also operates several clinics to serve low-income, elderly, and indigent patients.[8] These clinics are designated by the Agency for Health Care Administration as "area of critical need" facilities. This designation allows Comprehensive Medical Access to employ physicians licensed to practice medicine in states other than Florida, including Puerto Rico, who have been issued limited licenses by the Florida Board of Medicine. Comprehensive Medical Access pays these physicians less than it pays those licensed to practice medicine in Florida, and it can, therefore, serve more low-income, elderly, and indigent patients.

6. Currently, Comprehensive Medical Access clinics serve more than 50,000 low-income, elderly, and indigent patients.

Many of these patients would be eligible to participate in Comprehensive Medical Access's health flex plan, were its application to be approved.

7. Under Comprehensive Medical Access's business plan for operation as an entity offering a health flex plan, the various clinics it currently operates would provide general health care services for those enrolled in Comprehensive Medical Access's health flex plan, and Larkin Community Hospital would provide hospital services. Under the plan, these services would be provided to individuals participating in the health flex plan, who would pay a monthly fee to Comprehensive Medical Access and co-payments for some services when the services are provided.

8. In its application for approval to offer a health flex plan, Comprehensive Medical Access disclosed that Dr. Michel and his brother, George J. Michel, M.D., who is Comprehensive Medical Access's vice-president and medical director, had been named as defendants in a civil lawsuit filed by the United States of America in the United States District Court for the Southern District of Florida. Numerous defendants were named in the lawsuit, including Larkin Community Hospital and other entities in which Dr. Michel had ownership interests.

9. The 58-page complaint filed in the federal government's civil lawsuit included eight counts relating to two alleged schemes: The first scheme allegedly occurred in 1997 and

allegedly involved kickbacks paid by Larkin Community Hospital and related corporations to Dr. Michel, Dr. Michel's practice group, and Dr. George Michel in return for admitting patients to that hospital; many of the patients were allegedly covered by Medicare and many of the admissions were allegedly medically unnecessary. The second scheme allegedly occurred in 1998-1999, after Dr. Michel purchased Larkin Community Hospital, and allegedly involved the fraudulent increase of Medicaid and Medicare revenues by "churning" patients into that hospital from skilled nursing and assisted living facilities, some of which were owned by Dr. Michel, among others; many of the patients allegedly received medically unnecessary treatments while in Larkin Community Hospital.

10. Four counts of the civil complaint charged Dr. Michel and others with violations of the federal False Claims Act, Title 31, Section 3729(1)(1), United States Code, with respect to both the alleged 1997 scheme and the alleged 1998-1999 scheme; one count charged Dr. Michel and others with common law fraud with respect to both alleged schemes; one count charged entities owned by Dr. Michel and others with payment by mistake; one count charged Dr. Michel and others with unjust enrichment; and one count claimed that the government was entitled to "disgorgement of illegally earned monies."

11. The Florida Board of Medicine initiated disciplinary proceedings against Dr. Michel on the basis of the allegations in the civil complaint but dismissed the proceeding before hearing.

12. After the civil complaint was filed, the Agency for Health Care Administration ("AHCA") notified Larkin Hospital that it was suspending Medicaid payments as a result of the allegations in the civil complaint. Comprehensive Medical Access filed a lawsuit in circuit court seeking to enjoin AHCA from suspending Medicaid payments, and a temporary injunction was granted.

13. Dr. Michel testified during the evidentiary hearing conducted by the OIR on June 9, 2005[9]:

a. The allegations in the federal civil complaint arose from testimony given by an associate of the doctor from whom Dr. Michel purchased Larkin Hospital who had been convicted of participation in a kickback scheme in Illinois and who had received a sentence reduction for his testimony regarding Larkin Hospital;

b. The allegations regarding kickbacks were based on misunderstandings about the actual expenses incurred by his practice group relating to the provision of emergency room services at Larkin Hospital under a contract that was never executed, about the reasons for the large number of patient

referrals to Larkin Hospital by Dr. Michel and members of his practice group, and about the expenses incurred under the contract between Larkin Hospital and Dr. Michel's practice group for the provision of radiology services to the hospital;

c. The allegations in the civil complaint that Dr. Michel and entities he owned, operated, or controlled billed Medicaid and Medicare for services that were not medically unnecessary were based on audits that disallowed payment for excessive days of hospitalization, but, as a result of appeals, the total number of days disallowed was substantially decreased; and

d. Dr. Michel also testified in June 2005, that the parties in the civil lawsuit had reached a settlement in principal that he expected to be finalized within 60 days, with Larkin Hospital paying $10 million of the total proposed $15 million settlement amount. Dr. Michel categorized the decision to settle the case as a business decision on the part of all parties because it would be difficult to prove or disprove the allegations in the complaint. A settlement had not, however, been finalized at the time of the final administrative hearing in this case.

Ultimate finding of fact

14. The filing and pendency in federal court of the civil complaint containing allegations of wrongdoing, including payment of kickbacks and fraud, on the part of Dr. Michel and

healthcare-related entities he owned or operated or with which he was associated, are sufficient to raise the issue of Dr. Michel's fitness and trustworthiness as the owner and chief executive officer of Comprehensive Medical Access to operate Comprehensive Medical Access as an entity offering a health flex plan. Dr. Michel did not present any evidence during the hearing relating to the substance of the allegations contained in the civil complaint, but he did establish by credible and persuasive evidence that he is competent to own and operate an entity providing a health flex plan due to his experience in managing entities providing healthcare services, including clinics which primarily service low-income, elderly, and destitute patients; his knowledge about the healthcare services needed by these groups of individuals; and his familiarity with the health flex plan program enacted by the legislature in Section 408.909, Florida Statutes, and how such a plan could be put into operation. In addition, Dr. Michel appears to have in place the facilities and personnel to provide healthcare services under a health flex plan.

15. Nonetheless, the evidence presented by Dr. Michel is not sufficient to overcome the serious concerns regarding Dr. Michel's trustworthiness and fitness to own and operate Comprehensive Medical Access as an entity offering a health flex plan arising as a result of the pendency of the civil complaint

filed by the federal government. The explanations provided by Dr. Michel during the investigatory hearing before the OIR are insufficiently persuasive to overcome these reasonable concerns, as is the fact that the settlement pending in June 2005 has yet to be finalized. Comprehensive Medical Access has, therefore, failed to establish with the requisite degree of certainty that Dr. Michel is trustworthy and has not engaged in business operations in bad faith.

CONCLUSIONS OF LAW

16. The Division of Administrative Hearings has jurisdiction over the subject matter of this proceeding and of the parties thereto pursuant to Sections 120.569 and 120.57(1), Florida Statutes.[10]

17. Because Comprehensive Medical Access has applied for approval to offer a health flex plan, it has the burden of proving by a preponderance of the evidence that it meets all the requirements for receiving such approval. See Department of Banking & Fin. v. Osborne Stern, 670 So. 2d 932, 934 (Fla. 1996)("[W]hile the burden of producing evidence may shift between the parties in an application dispute proceeding, the burden of persuasion remains upon the applicant to prove her entitlement to the license.").[11]

18. Comprehensive Medical Access's burden in this case is the preponderance of the evidence. § 120.57(1)(j), Fla. Stat.

("Findings of fact shall be based upon a preponderance of the evidence, except in penal or licensure disciplinary proceedings or except as otherwise provided by statute . . . ."). The preponderance of the evidence standard requires proof by "the greater weight of the evidence," Black's Law Dictionary 1201 (7th ed. 1999), or evidence that "more likely than not" tends to prove a certain proposition. See Gross v. Lyons, 763 So. 2d 276, 289 n.1 (Fla. 2000)(relying on American Tobacco Co. v. State, 697 So. 2d 1249, 1254 (Fla. 4th DCA 1997) quoting Bourjaily v. United States, 483 U.S. 171, 175 (1987)).

19. Section 408.909, Florida Statutes, authorizes the approval of health flex plans and includes the criteria for approval of health flex plans, as well as certain requirements for eligibility to enroll in a health flex plan.

Section 408.909 provides in pertinent part:

> (3) PROGRAM.--The agency [Agency for Health Care Administration] and the office [Office of Insurance Regulation] shall each approve or disapprove health flex plans that provide health care coverage for eligible participants. . . .
>
> * * *
>
> (b) The office shall develop guidelines for the review of health flex plan applications and provide regulatory oversight of health flex plan advertisement and marketing procedures. The office shall disapprove or shall withdraw approval of plans that:
>
> * * *

> 4. Cannot demonstrate that the applicant and its management are in compliance with the standards required under s. 624.404(3).
>
> (c) The agency and the Financial Services Commission may adopt rules as needed to administer this section.[12]

20. Section 624.404(3)(a), Florida Statutes, provides:

> The office shall not grant or continue authority to transact insurance in this state as to any insurer the management, officers, or directors of which are found by it to be incompetent or untrustworthy; or so lacking in insurance company managerial experience as to make the proposed operation hazardous to the insurance-buying public; or so lacking in insurance experience, ability, and standing as to jeopardize the reasonable promise of successful operation; or which it has good reason to believe are affiliated directly or indirectly through ownership, control, reinsurance transactions, or other insurance or business relations, with any person or persons whose business operations are or have been marked, to the detriment of policyholders or stockholders or investors or creditors or of the public, by manipulation of assets, accounts, or reinsurance or by bad faith.

21. "[A]n agency has particularly broad discretion in determining the fitness of applicants who seek to engage in an occupation the conduct of which is a privilege rather than a right." Osborne Stern & Co. v. Department of Banking & Fin., 647 So. 2d 245, 250 (Fla. 1st DCA 1994)(Booth, J., dissenting). The OIR has no discretion under Sections 408.909(3)(b)3. and 624.404(3)(a) to grant an entity the authority to offer a health

flex plan if the OIR finds or "has good reason to believe" that the applicant's principals are incompetent, untrustworthy, or have engaged in business practices marked by bad faith. The authorization to offer a health flex plan to low income, elderly, and destitute individuals is clearly not a matter of right but is, rather, a privilege granted only to those entities that demonstrate to the OIR that, among other things, their principals are competent and trustworthy and have not engaged in business practices marked by bad faith.

22. The evidence presented by the OIR in this case, consisting exclusively of the civil complaint filed against Dr. Michel and entities he owns, operates, or in which he has an interest, does not establish that Dr. Michel or these entities committed the acts alleged in the complaint because, as Comprehensive Medical Access argues, the allegations in themselves are not evidence of wrongdoing. If an agency were seeking to impose disciplinary action on Comprehensive Medical Access or Dr. Michel or to suspend Comprehensive Medical Access's participation in state programs or payment for Medicaid or Medicare claims, the mere pendency of the civil complaint would not constitute evidence sufficient to sustain the penal action. But the pendency of the civil complaint is sufficient to give rise to reasonable and serious concerns regarding Dr. Michel's fitness and trustworthiness to own and operate an

entity offering a health flex plan, especially in light of the potential harm that could be suffered by low income and elderly individuals participating in the plan.

23. The evidence presented by Comprehensive Medical Access is simply insufficient to meet the burden imposed by Section 408.909(3)(b)3., Florida Statutes, and based on the findings of fact herein, Comprehensive Medical Access has failed to meet its burden of proving by a preponderance of the evidence that that it has complied with the standards in Section 624.404(3)(a), Florida Statutes.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Office of Insurance Regulation enter a final order denying the application of Comprehensive Medical Access, Inc., to offer a health flex plan.

DONE AND ENTERED this 1st day of November, 2006, in Tallahassee, Leon County, Florida.

PATRICIA M. HART
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 1st day of November, 2006.

ENDNOTES

[1]/ All references to the Florida Statutes herein are to the 2006 edition unless otherwise indicated.

[2]/ See discussion infra in endnote 11.

[3]/ The OIR stated in its "Proposed Recommended Order" that "the procedural aspects of the hearing were so fatally flawed that for the Office to proceed with submitting a traditional Proposed Recommended Order would serve no useful purpose as the Office was not permitted to make a record from which facts could be found." Respondent's "Proposed Recommended Order" at 4. In its proposed "Conclusions of Law," the OIR stated that the OIR has the authority to make decisions regarding trustworthiness and fitness for licensure pursuant to statute; that it had decided, on the basis of an investigatory evidentiary hearing it had conducted, that Dr. Michel, Comprehensive Medical Access's principal, was not fit or trustworthy; that its judgment that Comprehensive Medical Access's application should be denied was entitled to great weight in this administrative proceeding; and that the OIR's denial should be "affirmed": "Under Natelson an agency can make a determination that a civil action brought by a federal agency and the lack of proper responses, as demonstrated by the evidentiary hearing transcript in this matter [Respondent's Exhibit 1], is sufficient to find an applicant unfit and untrustworthy under the statute." Respondent's "Proposed Recommended Order" at 7 and 9.

These statements of the OIR's legal position in this case exhibit a misunderstanding of the nature of a de novo administrative hearing and the mistaken legal position that the determination of the trustworthiness of an applicant for licensure is a question of law within the exclusive jurisdiction of the OIR. As discussed infra in endnote 11, the purpose of the administrative hearing in this case was to "'formulate final agency action, not to review action taken earlier and preliminarily.'" Department of Transportation v. J.W.C., Co., 396 So. 2d 778, 787 (Fla. 1st DCA 1981)(citation omitted). And, as discussed infra in endnote 10, the issue of whether an applicant for licensure is trustworthy and competent and fit to

be issued a license or permit is a question of ultimate fact and not of law.

[4]/ Comprehensive Medical Access maintained in its request for an administrative hearing, and throughout this proceeding, that the civil complaint did not constitute evidence of wrongdoing and was an insufficient factual basis on which to base a finding that Comprehensive Medical Access did not meet the statutory criteria for approval as a health flex entity.

[5]/ The OIR protested at the hearing, in its "Proposed Recommended Order," and in its proffer, the undersigned's ruling denying its request that it be allowed to ask Dr. Michel questions and to receive answers "on the record" for its proffer and requiring instead that it submit a written proffer. The form of a proffer is, however, discretionary with the judge. See Porro v. State, 656 So. 2d 587, n. 1 (Fla. 3d DCA 1995).

[6]/ This is not to say, however, that such evidence would be irrelevant to Comprehensive Medical Access's case, which required affirmative proof that Dr. Michel was competent, fit, and trustworthy and that Comprehensive Medical Access's application should be approved. With the line of questioning proposed in its proffer, the OIR would essentially have been taking up the burden of proving that Dr. Michel was unfit and untrustworthy, a burden that was Comprehensive Medical Access's to satisfy. See discussion infra in endnote 11.

[7]/ Section 408.909, Florida Statutes, sets forth the purpose of health flex plans as follows:

> (1) INTENT.--The Legislature finds that a significant proportion of the residents of this state are unable to obtain affordable health insurance coverage. Therefore, it is the intent of the Legislature to expand the availability of health care options for low-income uninsured state residents by encouraging health insurers, health maintenance organizations, health-care-provider-sponsored organizations, local governments, health care districts, or other public or private community-based organizations to develop alternative approaches to traditional health insurance which emphasize coverage for basic and

> preventive health care services. To the maximum extent possible, these options should be coordinated with existing governmental or community-based health services programs in a manner that is consistent with the objectives and requirements of such programs.

[8]/ These clinics were previously operated by an entity known as the Project Access Foundation, and it was this entity that submitted the original application for approval to participate in the health flex plan pilot program. Comprehensive Medical Access was created at the request of the OIR, and a second subsequent application, which is the subject of this proceeding, was filed with the OIR by Comprehensive Medical Access.

[9]/ Comprehensive Medical Access chose not to submit evidence related to the truth or falsity of the allegations contained in the civil complaint but, rather, relied on its theory of the case that the allegations in the civil complaint were not evidence of wrongdoing and, in fact, had no evidentiary value whatsoever. Therefore, the only evidence presented in this case relating to the allegations in the civil complaint was the testimony given by Dr. Michel at the investigatory hearing conducted by the OIR. The transcript of this hearing was presented by the OIR in Respondent's Exhibit 1. The substance of Dr. Michel's testimony has been considered in this proceeding under Section 90.803(18), Florida Statutes, which provides an exception to the hearsay rule for admissions of a party offered against that party, but the evidence has been considered for the purpose of presenting Dr. Michel's explanation of his position on the allegations in the civil complaint.

[10]/ On July 12, 2006, the OIR filed a Motion to Relinquish Jurisdiction and Close File, asserting that, based on the July 21, 2005, letter of denial and on the Petitioner's Pre-Hearing Stipulation, there were no disputed issues of material fact to be resolved in an evidentiary hearing and that the only issues to be resolved were legal issues. The "disputed issues of fact" to which the OIR referred in its motion were stated in the Petitioner's Pre-Hearing Stipulation as: "1. Whether the applicant and its management have demonstrated compliance with the standards required under Section 624.404(3)"; and "2. Whether the Department [sic] of Insurance Regulation can deny a license to Petitioner based upon the fact that the

Department of Justice has filed a civil law suit (still pending) for alleged misconduct between March, 1997 and December, 1999."

Comprehensive Medical Access filed a response in opposition to the Motion to Relinquish Jurisdiction, in which it argued that the question of whether Comprehensive Medical Access had complied with the requirements of Section 624.404(3), Florida Statutes, was a disputed issue of material fact. In the response, Comprehensive Medical Access stated that it anticipated that the OIR would offer the existence of a civil complaint as its only evidence that Comprehensive Medical Access was not in compliance with the requirements of Section 624.404(3), Florida Statutes. The OIR filed a reply to Comprehensive Medical Access's response, in which it re-asserted its contention that there were no disputed issues of fact to be litigated in a proceeding conducted pursuant to Section 120.57(1), Florida Statutes: "There is no dispute that a Civil Complaint was filed by the U.S. Attorney against Petitioner and others. The matter at hand here regards only legal issues," specifically, whether Dr. Michel meets the criteria in Section 624.404(3), Florida Statutes. The OIR's motion was denied in an order entered July 14, 2006, in which Langston v. Jamerson, 653 So. 2d 489, 491 (Fla. 1st DCA 1995), was cited for the well-established rule that "the question of whether an applicant for licensure has met statutory standards, such as trustworthiness or competence, is a question of fact."

Shortly after the final hearing convened, the OIR renewed its motion to relinquish jurisdiction and again argued that there were no disputed issues of material fact and that the matter should be returned to the OIR for an informal hearing pursuant to Section 120.57(2), Florida Statutes. Counsel for the OIR argued in pertinent part:

> If and when you review the Petitioner's memorandum of law filed yesterday,* you will see that the parties agreed that there was a civil complaint that was filed by the U.S. Department of Justice against Dr. Jack Michel as one of the defendants.
>
> You will see that the [OIR] reviewed the application that was submitted by Dr. Michel through Comprehensive Medical Access, Inc. for approval as a health flex plan.

> You will also see that said application was disapproved pursuant to sections 408.909, and 624.404 of the Florida Statutes.
>
> It was disapproved because the [OIR] concluded that Dr. Michel was not trustworthy or competent to grant the licensure that he was applying for.
>
> There are no disputed issues of material fact. When there are no issues, the proper venue is before the Agency pursuant to Section 120.57(2), Florida Statutes.

Transcript at page 19. *(Note: On the day before the hearing, Comprehensive Medical Access filed Petitioner's Memorandum of Law in Support of Vacating the Office of Insurance Regulation's Denial and Ordering the Office of Insurance Regulation to Approve Petitioner's Application for Participation in the Health Flex Program, in which it argued that the basis for the OIR's denial of Comprehensive Medical Access's application was insufficient to establish that Comprehensive Medical Access was not in compliance with the statutory requirements for approval to participate in the health flex plan pilot program. Among other arguments, Comprehensive Medical Access contended in its memorandum that the allegations contained in the civil complaint were not evidence of any wrongdoing and could not form the basis for OIR's denial of its application.)

At the hearing, the OIR supplemented the argument made in its written motion to relinquish jurisdiction with citation to Natelson v. Department of Insurance, 454 So. 2d 31 (Fla. 1st DCA 1984), to support its contention that the only issue for determination in this proceeding, whether the filing of a civil complaint against Dr. Michel is sufficient to establish that he is not "trustworthy or competent," is not a factual issue but a legal issue properly resolved by the OIR. The OIR relied on the specific holding in Natelson that it would defer to "the department's construction of the term 'lack of fitness or trustworthiness to engage in business of insurance' as including the conviction of criminal conspiracy to traffic in illicit drugs" because that construction "is well within the range of possible constructions." Id. at 32. Counsel for Comprehensive Medical Access argued in opposition to the motion that the

question of whether "a mere civil complaint that is pending is enough for denial of the health flex license" is a question of fact. Transcript at page 22-23.

At the OIR's request, ruling on the renewed motion was reserved until the conclusion of the evidence. The OIR reiterated at the conclusion of the evidence its contention that there was no dispute regarding the fact that the civil complaint had been filed against Dr. Michel and that the issue of whether Dr. Michel was competent and trustworthy was an issue of law that is within the purview of the OIR. The renewed motion to relinquish was again denied.

Subsequent to the hearing, the undersigned has had the opportunity to review the Natelson case and to conduct additional research on the issue presented by the OIR in its motion to relinquish jurisdiction. The court in Natelson did not address the issue of whether a determination of lack of fitness or trustworthiness or competence is a question of law to be resolved by the OIR or a question of fact to be resolved by an administrative law judge. Rather, the court in Natelson simply assumed that the issue presented involved statutory interpretation and relied for its holding on the well-established rule requiring appellate courts, on review of final agency action, to defer to an agency's interpretation of a statute: "Agencies are afforded wide discretion in the interpretation of a statute which it administers and will not be overturned on appeal unless clearly erroneous. (Citations omitted.) The reviewing court will defer to any interpretation within the range of *possible* interpretation." 454 So. 2d at 32 (emphasis in original). The court's specific holding in Natelson has been followed in only one case, Paisley v. Department of Insurance, 526 So. 2d 167 (Fla. 1st DCA 1988), another case in which the court did not address the issue of whether the determination of "lack of fitness or trustworthiness" was a matter of law or fact.

There is an equally well-established rule, followed in Langston, "that the issue of whether an individual violated a statute or deviated from a standard of conduct is generally an issue of fact to be determined by the administrative law judge based on the evidence and testimony." Gross v. Department of Health, 819 So. 2d 997, 1003 (Fla. 5th DCA 2002). See, e.g., Palamara v. Department of Bus. & Prof'l Regulation, 855 So. 2d 706 (Fla. 4th DCA 2003)(whether applicant was of good moral character is a factual issue); Gross (whether physician breached

standard of care is a factual issue) and cases cited therein; Goin v. Commission on Ethics, 658 So. 2d 1131 (Fla. 1st DCA 1995)(whether facts constitute violation of statute or rule is question of ultimate fact); Nest v. Department of Prof'l Regulation, Bd. of Med. Exam'rs, 490 So. 2d 987 (Fla. 1st DCA 1986)(whether physician could practice medicine with reasonable skill and safety is a question of ultimate fact). This rule derives from the principal of law that matters "susceptible of ordinary methods of proof, such as determining the credibility of witnesses or the weight to be given particular evidence . . . should be determined by the hearing officer." Pillsbury v. Department of Health & Rehabilitative Serv., 744 So. 2d 1040, 1042 (Fla. 2d DCA 1999). Significantly, the court in Langston rejected an argument of the Education Practices Commission that is virtually identical to the argument accepted by the court in Natelson:

> The EPC takes the position that it was not bound by the hearing officer's findings that no students were harmed, embarrassed or felt disparaged because the members of the EPC were entitled to decide that the events which took place in Mr. Langston's classroom had the potential to cause harm, embarrassment or a sense of disparagement, and that the hearing officer therefore misconstrued the application of these two rules. . . . [T]his argument by the EPC must be rejected because the question whether a particular action constituted a violation of one of these two rules is a factual question to be decided in the context of the alleged violation. (Citation omitted.) The question whether the facts, as found in the recommended order and adopted by the EPC, constituted violations of these rules, was a question of ultimate fact which the agency erred in rejecting without adequate explanation. See Holmes v. Turlington, 480 So. 2d 150, 153 (Fla. 1st DCA 1985)(whether there was a deviation from the required standard of conduct is not a conclusion of law, it is an ultimate finding of fact

> within the fact-finding discretion of the hearing officer.

653 So. 2d at 491.

Having again considered the arguments of the OIR in support of its motion to relinquish jurisdiction, and having carefully reviewed the Natelson case and conducted additional research on the issue presented by the OIR, the undersigned has not been persuaded to alter the rulings denying the OIR's motions to relinquish jurisdiction. The issue of whether Dr. Michel, the principal of Comprehensive Medical Access, meets the criteria of Section 624.404(3), Florida Statutes, is a question of fact. Comprehensive Medical Access is entitled to an evidentiary hearing at which it can present evidence to establish that Dr. Michel is competent and trustworthy and has not acted in bad faith in his business operations, even though there is no dispute that that the United States has filed a civil complaint against Dr. Michel and entities that he wholly or partially owns. Cf. Shapiro v. Department of Bus. & Prof'l Regulation, 623 So. 2d 1235, 1236 (Fla. 4th DCA 1993)(applicant not entitled to formal hearing when no dispute that he was reprimanded in another state where applicable statute authorized board to deny license to applicant whose license had been "acted against" by another state).

[11]/ After submission into evidence, as joint exhibits, of Comprehensive Medical Access's application for approval to offer a health flex plan, together with the supporting documentation, and of the civil complaint filed by the federal government against Dr. Michel and others, the undersigned asked the OIR to present any additional evidence it might have to support its proposed denial of Comprehensive Medical Access's application. The OIR objected to this request, arguing that, if it were required to present its evidence first, prior to Comprehensive Medical Access's presentation of evidence related to Dr. Michel's fitness and trustworthiness, it was, in essence, being required to carry the burden of proof in the case. Despite being repeatedly assured that Comprehensive Medical Access had the burden of proving entitlement to offer a health flex plan and that the OIR was being asked only to present any evidence it might have supporting its preliminary denial of the application, counsel for the OIR made "numerous objections" to presenting its case "first." After extensive discussion of the issue, the OIR was directly ordered to present its case.

Respondent's "Proposed Recommended Order" at 4,5; Transcript at 26 through 29 and 36 through 41.

Counsel for the OIR raised the objection again in its post-hearing submission, asserting that the undersigned had committed "clear procedural error that prejudiced the Office in the presentation of its case" and that "[f]rom the commencement of the proceeding and the erroneous requirement that in a license denial case the agency was required to put its case on first, this proceeding is fatally flawed." Respondent's "Proposed Recommended Order" at 4, 5. The OIR's position on this issue reveals a fundamental misunderstanding of the nature of a de novo hearing involving the denial of an application for a license or permit and of the distinction between the burden of proof and the shifting burden of producing evidence in a license application proceeding.

The court in Department of Transportation v. J.W.C. Co., Inc., 396 So. 2d 778 (Fla. 1st DCA 1981), addressed a number of basic rules governing administrative proceedings under Section 120.57(1), Florida Statutes, which are particularly pertinent to the issues raised by the OIR in its objections. First, the court in J.W.C. explained that an agency's letter of intent to deny an application for a license or permit is "proposed agency action" that becomes final only if a hearing is not requested to challenge the proposed denial and that, consequently, a "request for a hearing commence[s] a de novo proceeding, which . . . is intended to 'formulate final agency action, not to review action taken earlier and preliminarily.'" Id. at 786-87.

The court in J.W.C. also discussed the requirement that an applicant present a prima facie case in a proceeding involving the proposed denial of a license or permit:

> As a practical matter, where a notice of intent has been issued, we can conceive of no more orderly way for a formal hearing to be conducted than to have the applicant (who has the ultimate burden of persuasion) first present a "prima facie case." . . . At the very minimum, this preliminary showing should include the application, and the accompanying documentation and information relied upon by the agency as a basis for the issuance of its notice of intent. To what

> extent it would be advisable or necessary for this preliminary presentation by the applicant to be further expanded would depend, to a large extent, on the nature of the objections raised by the petitioners requesting a hearing.

396 So. 2d at 788.

Finally, the court in J.W.C. explained that it is

> fundamental that an applicant for a license or permit carries the 'ultimate burden of persuasion' of entitlement through all proceedings, of whatever nature, until such time as final action has been taken by the agency. This burden is not subject to any 'shifting' by the hearing officer, although it is entirely possible that a shifting of the burden of going forward with the evidence may occur during the course of the . . . proceeding.

Id. at 787. The court in Department of Banking & Fin. v. Osborne Stern & Co., 670 So. 2d 932, 934 (Fla. 1996), further explicated this principle:

> [W]e agree with the analysis of Judge Booth explaining that in license application proceedings:
>
> > [T]he majority is correct in its observation that appellants [applicants] had the burden of presenting evidence of their fitness for registration. The majority is also correct in holding that the Department had the burden of presenting evidence that appellants had violated certain statutes and were thus unfit for registration. . . . [A]n applicant for licensure bears the burden of ultimate persuasion at each and every step of the licensure proceedings, regardless

> of which party bears the burden of presenting certain evidence. . . .
>
> Osborne [Stern & Co. v. Department of Banking & Fin.,] 647 So. 2d [245] at 250(Booth, J., concurring and dissenting)(citations omitted).

Although J.W.C. concerned a proceeding initiated by property owners challenging the Department of Environmental Regulation's proposed approval of a permit for the Department of Transportation to construct a highway, the principles established in the case apply in the instant case. Comprehensive Medical Access was required, first, to establish a prima facie case so that there was "on record a basic foundation of evidence pertaining to the application so that the issues can be understood." J.W.C., 396 So. 2d at 788. Under the circumstances of this case, a prima facie case of entitlement to approval was established when the OIR and Comprehensive Medical Access jointly introduced into evidence Comprehensive Medical Access's application and the supporting documentation. It was not necessary for Comprehensive Medical Access to go further in its prima facie case and prove the truth or completeness of any element of its application because nothing in the application was controverted by the OIR. The OIR did not base its proposed decision to deny Comprehensive Medical Access's application on the contents of Comprehensive Medical Access's application but, rather, on matters extraneous to the application itself. Therefore, once the application and documentation was in evidence, it was the burden of the OIR "to go forward with evidence" to establish the basis for its proposed denial. Id. at 789.

Comprehensive Medical Access, as the applicant, had the ultimate burden of proving by a preponderance of the evidence that its application should be approved. The OIR, as the agency proposing to deny the application, had the burden of presenting evidence establishing its objection to granting Comprehensive Medical Access's application, which, in this case, consisted of the undisputed fact that a civil complaint had been filed by the federal government against Dr. Michel and others alleging fraud, false claims, and a kickback scheme and of whatever other evidence the OIR wished to present to establish that, because of this civil complaint, Comprehensive Medical Access did not meet the statutory criteria required for approval to offer a health flex plan.

The OIR was not "put in the posture of proving Petitioners [sic] lack of fitness and trustworthiness and bad faith" in this proceeding. Respondent's "Proposed Recommended Order" at 5. It was merely required to present evidence as to the basis for its preliminary decision to deny Comprehensive Medical Access's application in order to narrow the issues that Comprehensive Medical Access was required to address. Comprehensive Medical Access retained throughout this proceeding the burden of proving by a preponderance of the evidence that it met the statutory criteria for approval of its application to offer a health flex plan, that is, as narrowed by the OIR, that Dr. Michel, as Comprehensive Medical Access's principal, was fit and trustworthy and competent.

[12]/ Neither Comprehensive Medical Access nor the OIR included reference to any rules enacted under this authority.

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NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this recommended order. Any exceptions to this recommended order should be filed with the agency that will issue the final order in this case.