

STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

CARE ACCESS PSN, LLC,

Petitioner,

vs.

Case No. 13-4113BID

AGENCY FOR HEALTH CARE
ADMINISTRATION,

Respondent,

and

PRESTIGE HEALTH CHOICE, LLC,

Intervenor.

RECOMMENDED ORDER

This case came before Administrative Law Judge John G. Van Laningham for final hearing on November 18 and 19, 2013, in Tallahassee, Florida.

APPEARANCES

For Petitioner: Frank P. Rainer, Esquire
M. Stephen Turner, Esquire
Lacey D. Corona, Esquire
Broad and Cassel
215 South Monroe Street, Suite 400
Tallahassee, Florida 32301

For Respondent: Segundo J. Fernandez, Esquire
M. Christopher Bryant, Esquire
Timothy P. Atkinson, Esquire
Timothy J. Perry, Esquire
Oertel, Fernandez, Bryant
and Atkinson, P.A.
Post Office Box 1110
Tallahassee, Florida 32302-1110

Stuart F. Williams, General Counsel
William M. Blocker, II, Esquire
David W. Nam, Esquire
Agency for Health Care Administration
Fort Knox Building 3, Mail Stop 3
2727 Mahan Drive
Tallahassee, Florida 32308

Joseph M. Goldstein, Esquire
Shutts and Bowen, LLC
Wachovia Center, Suite 2100
200 East Broward Boulevard
Fort Lauderdale, Florida 33301

For Intervenor Prestige Health Choice, LLC:

Martha Harrell Chumbler, Esquire
Kelly Cruz-Brown, Esquire
M. Kip Krieger, Esquire
Carlton Fields, P.A.
215 South Monroe Street, Suite 500
Post Office Drawer 190
Tallahassee, Florida 32302-0190

For Intervenor Amerigroup Florida, Inc.:

Robert H. Hosay, Esquire
James A. McKee, Esquire
Foley and Lardner, LLP
106 East College Avenue, Suite 900
Tallahassee, Florida 32301

John A. Tucker, Esquire
Foley and Lardner, LLP
One Independent Drive, Suite 1300
Jacksonville, Florida 32202

For Intervenor Humana Medical Plan, Inc.:

Seann M. Frazier, Esquire
Thomas D. Watry, Esquire
Parker Hudson, Rainer
and Dobbs, LLP
215 South Monroe Street, Suite 750
Tallahassee, Florida 32301

For Intervenor Simply Healthcare Plans, Inc.:

Bruce Douglas Lamb, Esquire
Gunster, Yoakley and Stewart, P.A.
401 East Jackson Street, Suite 2500
Tampa, Florida 33602

George Lemieux, Esquire
Gunster, Yoakley and Stewart, P.A.
450 East Las Olas Boulevard, Suite 1400
Fort Lauderdale, Florida 33301

Terry Cole, Esquire
Kellie Scott, Esquire
Gunster, Yoakley and Stewart, P.A.
215 South Monroe Street, Suite 601
Tallahassee, Florida 32301

For Intervenor Sunshine State Health Plan, Inc.:

Michael J. Glazer, Esquire
Stephen C. Emmanuel, Esquire
Erik M. Figlio, Esquire
Ausley McMullen
Post Office Box 391
Tallahassee, Florida 32301

For Intervenor Wellcare of Florida, Inc.:

Geoffrey D. Smith, Esquire
Corinne Porcher, Esquire
Timothy B. Elliott, Esquire
Smith and Associates
2834 Remington Green Circle, Suite 201
Tallahassee, Florida 32308

For Intervenor UnitedHealthcare of Florida, Inc.:

George N. Meros, Jr., Esquire
William E. Williams, Esquire
Amy W. Schrader, Esquire
D. Ty Jackson, Esquire
Andy Bardos, Esquire
GrayRobinson, P.A.
301 South Bronough Street, Suite 600
Post Office Box 11189
Tallahassee, Florida 32302-3189

For Intervenor Molina Healthcare of Florida, Inc.:

W. Robert Vezina, III, Esquire
Eduardo S. Lombard, Esquire
Megan S. Reynolds, Esquire
Vezina, Lawrence and Piscitelli, P.A.
413 East Park Avenue
Tallahassee, Florida 32301

STATEMENT OF THE ISSUES

The issues in this bid protest are whether, in making the decision to award Intervenor Prestige Health Choice, LLC ("Prestige"), a contract to provide Medicaid managed medical assistance services as a provider service network in Region 11 (covering Miami-Dade and Monroe Counties), Respondent Agency for Health Care Administration ("AHCA") acted contrary to a governing statute, rule, or solicitation specification; and, if so, whether such action was clearly erroneous, contrary to competition, arbitrary, or capricious. (In this protest, Petitioner Care Access PSN, LLC ("Care Access"), challenges AHCA's intended award to Prestige in Region 11, and only that award. Care Access does not seek to upset any other intended awards in Region 11 or in any other Region.)

PRELIMINARY STATEMENT

On December 28, 2012, AHCA issued Invitation to Negotiate No. 027-12/13 for the purpose of soliciting replies from health plans seeking to provide managed medical assistance services to Medicaid enrollees in Region 11. AHCA received bids from Care

Access and Prestige, along with bids from a dozen other "standard plans," including those of: Intervenors Amerigroup Florida, Inc. ("Amerigroup"); Humana Medical Plan, Inc. ("Humana"); Simply Healthcare Plans, Inc. ("Simply"); Sunshine State Health Plan, Inc. ("Sunshine"); Wellcare of Florida, Inc. ("Wellcare"); UnitedHealthcare of Florida, Inc. ("United"); and Molina Healthcare of Florida, Inc. ("Molina").^{1/}

On September 23, 2013, AHCA announced its intent to award contracts in Region 11 to Sunshine, Wellcare, Humana, United, Preferred Medical Plan ("Preferred"), and Prestige.^{2/} Care Access timely filed a Notice of Protest, and on October 4, 2013, it filed a formal written protest of the intended action. AHCA referred Care Access's formal protest to the Division of Administrative Hearings ("DOAH") on October 17, 2013, where—the next day—it was assigned to the undersigned.^{3/}

By order dated November 5, 2013, Prestige, Amerigroup, Humana, Simply, Sunshine, Wellcare, United, and Molina were granted leave to intervene.

The final hearing took place as scheduled on November 18 and 19, 2013. At the final hearing, Joint Exhibits 1 through 5 were admitted into evidence. Care Access presented the in-person testimony of four witnesses: Luis Mosquera, CEO of Care Access; Jennifer Barrett, Bureau Chief of Support Services for AHCA; Kevin Kearns, CEO of Prestige; and Gerald Sternstein,

president of Care Access. In addition, Care Access introduced the depositions of Mr. Kearns; Dwight Chenette, president of Florida True Health and a member of Prestige's board; Steven Bohner, an officer and the CFO of AmeriHealth Caritas and a board member of both Prestige and Florida True Health; Brian Fox, a board member of Prestige; and Joyce Kramzer, an officer of Florida Blue and a board member of both Florida True Health and Prestige. Finally, Care Access offered 23 exhibits (Petitioner's Exhibits 1, 2, 4, 5, 9, 10, and 12 through 28), which were received into evidence.

Care Access and AHCA jointly offered the depositions of: Ms. Barrett; Shevaun Harris, Chief of Medicaid Services; Abby Riddle, AHCA Senior Management Analyst; and David Rogers, Assistant Deputy Secretary for Medicaid Health Systems.

AHCA called no witnesses to the stand during its case-in-chief, relying instead on the prior hearing testimony of Ms. Barrett, the depositions admitted into evidence, and the exhibits. In addition to the jointly introduced depositions, AHCA introduced the depositions of Doug Cook, a founder of Prestige; Mr. Mosquera; and Mr. Sternstein. AHCA also offered forty exhibits (Respondent's Exhibits 1 through 10, 12 through 17, and 36 through 59), which were received into evidence.

Prestige presented the testimony Mr. Kearns and, additionally, offered two exhibits (Prestige's Exhibits 10

and 14), which were received into evidence. None of the other intervenors called any witnesses or offered any exhibits at the final hearing.

The final hearing transcript was filed on December 3, 2013, making the proposed recommended orders due on December 13, 2013, pursuant to the schedule established at the conclusion of the final hearing. Care Access, AHCA, and Prestige each timely filed a Proposed Recommended Order, as did Simply and, as a group, Amerigroup, Humana, Molina, Sunshine, United, and Wellcare.

On December 20, 2013, Prestige filed a motion to strike portions of Care Access's Proposed Recommended Order. This motion is denied.

Unless otherwise indicated, citations to the Florida Statutes refer to the 2013 Florida Statutes.

FINDINGS OF FACT

1. On December 28, 2012, AHCA issued 11 separate invitations to negotiate, one for each region of Florida as established by the legislature in section 409.966, Florida Statutes. These invitations to negotiate solicited proposals from vendors seeking contracts to provide managed medical assistance services to Medicaid enrollees. The goal of these interrelated procurements was (and remains) to enable AHCA, as the agency responsible for administering the Medicaid program,

to purchase medical goods and services for all Medicaid recipients throughout the entire state of Florida on a managed care basis instead of under a fee-for-service payment model.

2. At issue in this case is Invitation to Negotiate No. 027-12/13 (the "ITN"), which sought proposals from eligible plans^{4/} to provide services to Medicaid enrollees in Region 11, which consists of Miami-Dade and Monroe Counties. In compliance with section 409.974(1)(k), Florida Statutes, the ITN stated that AHCA intended to enter into at least five contracts and up to ten contracts in Region 11, with at least one of those contracts being awarded to a provider service network ("PSN"), if a responsive bid from a responsible PSN were received.

3. Fourteen plans responded to the ITN. Four of the bidders identified themselves as PSNs: Care Access; Prestige; Salubris PSN; and South Florida Community Care Network PSN. The other ten bidders were health maintenance organizations ("HMOs").

4. As described in the ITN, the evaluation phase of the selection process consisted of the following components: (1) evaluation of mandatory criteria; (2) evaluation of financial stability; (3) review and scoring of comments from enrolled Medicaid providers regarding the vendor; (4) review and scoring of the vendor's past performance; and (5) evaluation and

scoring of the technical responses. AHCA appointed 28 evaluators to evaluate and score the bids.

5. At the completion of the evaluation phase, AHCA tabulated the evaluators' scores and ranked the 14 Region 11 bids from first to last. The HMOs occupied the first 10 places, followed by Prestige (No. 11), Care Access (No. 12), and the other two PSNs. Thereafter, in July 2013, AHCA invited the eight highest-ranked HMOs and the two highest-ranked PSNs (Prestige and Care Access) to participate in negotiations.

6. AHCA held three negotiation sessions apiece with the ten vendors who advanced to this phase of the competition. Following these negotiations, AHCA presented the vendors with an offer of the contractual terms AHCA sought, including a composite capitation rate and a list of expanded benefits to be covered by the plans. Vendors were instructed to accept AHCA's proposed terms or make a counteroffer.

7. On September 23, 2013, AHCA gave notice of its intent to award contracts in Region 11 to six plans, including Prestige, which was the only PSN to receive an intended award. AHCA later notified the public that four additional contracts would be awarded in Region 11, each to an HMO. With these announcements, which brought to ten the total number of intended awards, AHCA reached the maximum number of contracts it can

offer in Region 11. Care Access was not selected for an intended award in Region 11.

8. Care Access timely initiated the instant protest, seeking to have Prestige disqualified from the competition or, failing that, the proposed award to Prestige set aside for reasons independent of Prestige's alleged ineligibility. While Care Access protests the intended award on numerous grounds, the principal objective of this challenge is to establish that Prestige is not really a PSN, which if true would mean that AHCA's intended award is contrary to the mandate of section 409.974(1)(k) that at least one contract in Region 11 be let to a PSN. In this regard, Care Access contends that Prestige fails to meet the PSN provider control and financial interest requirements (about which more will be said) for two separate but related reasons, namely: (a) an HMO named Florida True Health ("FTH"), rather than a group of affiliated health care providers, effectively owns and controls Prestige; and (b) Prestige is not majority-owned (over 50%) by a group of affiliated health care providers.

9. Care Access's position relating to FTH's alleged control of Prestige is based on the undisputed facts that FTH not only owns 40% of Prestige's shares, but also holds an option, which it can exercise at any time until December 31, 2020, to purchase the remaining 60%. Relying on the contractual

instruments behind the complex transaction by which FTH purchased both its 40% stake in Prestige and the option to acquire the entire company, Care Access argues that FTH has already taken over Prestige through a "virtual merger," even though the option it holds has not yet been formally exercised. If this were the case, Prestige clearly would not be a provider-operated PSN, because FTH is not a health care provider.

10. Concerning the requirement that a PSN be majority-owned by providers, Care Access asserts that affiliated health care providers, as a group, own less than 50% of Prestige because, even if FTH is merely a minority shareholder, one of the putative "provider owners"—Health Choice Network of Florida, Inc. ("HCNF")—is actually not a provider. There is no dispute that HCNF owns 13.333% of Prestige. There can be no dispute that if, in determining whether Prestige meets the PSN ownership requirement, HCNF's 13.333% interest were subtracted from the sum of Prestige's "provider ownership," Prestige would not be majority-owned by a group of health care providers (because, as everyone agrees, at least 40% of Prestige is owned by non-provider FTH)—and thus it would fail one of the tests for determining PSN status.

11. Care Access's remaining protest grounds can be boiled down to three salient objections: (1) Prestige's bid deviated materially from the ITN specifications because the electronic

version of the document Prestige submitted which identified its network providers had been saved in a file format not supported in Microsoft Excel, a popular spreadsheet application;

(2) Prestige improperly colluded with FTH, the HMO with which it has a business relationship; and (3) AHCA's decision to set a base price neutralized any competitive advantage for having the lowest bid, in violation of the statutory directive to achieve the "best value" for the state.

12. As mentioned above, the ITN provides that "[a]t least one (1) award in this Region will be to a PSN provided a PSN submits a responsive reply and negotiates a rate acceptable to the Agency." The principal statutory definition of a PSN is set forth in section 409.912, Florida Statutes, which states as follows:

(4) [For the purpose of purchasing goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care, the] agency may contract with:

* * *

(d)1. A provider service network, which may be reimbursed on a fee-for-service or prepaid basis. Prepaid provider service networks shall receive per-member, per-month payments. A provider service network that does not choose to be a prepaid plan shall receive fee-for-service rates with a shared savings settlement. The fee-for-service option shall be available to a provider service network only for the first 2 years of the plan's operation or until the

contract year beginning September 1, 2014, whichever is later.

* * *

4. A provider service network is a network established or organized and operated by a health care provider, or group of affiliated health care providers, including minority physician networks and emergency room diversion programs that meet the requirements of s. 409.91211, which provides a substantial proportion of the health care items and services under a contract directly through the provider or affiliated group of providers and may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians, by other health professionals, or through the institutions. The health care providers must have a controlling interest in the governing body of the provider service network organization.

(Emphasis added.)^{5/}

13. Section 409.962(13) supplies another, slightly different definition of the term:

"Provider service network" means an entity qualified pursuant to s. 409.912(4)(d) of which a controlling interest is owned by a health care provider, or group of affiliated providers, or a public agency or entity that delivers health services. Health care providers include Florida-licensed health care professionals or licensed health care facilities, federally qualified health care centers, and home health care agencies.

14. The ITN required each bidder to include, with its submission, a signed Exhibit C-3 titled "Required Certifications and Statements." Item No. 8 of Exhibit C-3 required the bidder to certify that it was a type of plan eligible to respond to the ITN. Prestige certified its eligibility as a PSN by marking the following box:

I hereby certify that my company currently operates as one (1) of the following:

* * *

Provider Service Network (PSN) qualified by Section 409.912(4)(d), Florida Statutes, which is majority owned (over 50%) by a health care provider, group of affiliated providers, public agency, or entity that delivers health services (Section 409.962(13), Florida Statutes), and possess a Florida Third Party Administrative License or a subcontract/letter of agreement with a Florida-licensed Third Party Administrator.

In addition, the respondent shall complete Exhibit C-4, Disclosure of Ownership and Control Interest Statement (CMS 1513).

(Emphasis added.)

15. Prestige's certification was at least partially true. Prestige is a Florida limited liability company that was established in 2007 by a group of Florida-based, federally qualified health centers ("FQHC"s) and community mental health centers. First accepted by AHCA as a PSN in 2008, Prestige has provided services under continuous contract with AHCA ever

since, with the most recent contract renewal effective October 1, 2013.

16. The ITN, however, added a requirement that the statutes do not impose, i.e., that a network, to be a PSN, must be majority-owned (over 50%) by a provider or group of affiliated providers. Recall that the statutes, in contrast, mandate that a provider or group of affiliated providers have "a controlling interest" in both the entity and its governing body, which is not the same as owning a majority of its shares.^{6/} While owning more than 50% of a corporation is likely to ensure a controlling interest in the entity, having a controlling interest is not dependent upon or tantamount to majority ownership. As both AHCA and Prestige acknowledge in their respective proposed recommended orders, it is possible for a minority shareholder or group of affiliated shareholders whose combined ownership is less than 50% to have a controlling interest in a corporation.^{7/} It is possible, therefore, for an entity to satisfy the definitions of a PSN under sections 409.912(4) and 409.962(13) because a group of affiliated providers have a controlling interest in the network, and yet not be eligible for an award as a PSN pursuant to the ITN because the group of affiliated providers' combined ownership interests total less than 50%.

17. As required by Item No. 8 of Exhibit C-3, Prestige submitted a fully executed Exhibit C-4, the form titled "Disclosure of Ownership and Control Interest Statement." This instrument—a form whose provenance is the Centers for Medicare and Medicaid Services—is commonly known as a "CMS 1513." In its CMS 1513, Prestige divided its shareholders into two categories: "Provider Owners" and "Other Owners." Within the category of Provider Owners, Prestige identified three subcategories: "Health Choice Network of Florida, Inc.-FQHC Controlled Network"; "FQHC Owners"; and "Other Provider Owners." The category of Other Owners, comprising non-providers, was not subdivided.^{8/}

18. Under the respective subcategories of Provider Owners, Prestige named the shareholder or shareholders belonging to each subset; disclosed each shareholder's percentage of ownership; and provided a subtotal of the aggregate ownership interests within each subcategory. So, under the subcategory of Health Choice Network of Florida, Inc.-FQHC Controlled Network, one entity was identified, i.e., HCNF, whose 13.333% stake represented the subtotal of ownership for that subcategory. Under the subcategory of FQHC Owners, 17 separate entities were listed, whose respective interests added up to a subtotal of 21.139%. Under the subcategory of Other Provider Owners, Prestige enumerated 12 shareholders, some of whom are

individuals, and others of which appear to be facilities or organizations. The subtotal of the Other Provider Owners' interests was shown to be 23.364%. For the whole category of Provider Owners, Prestige represented that the combined ownership interests—the sum of the several subtotals—amounted to 57.836%.

19. In addition to the CMS 1513, PSN applicants needed to complete and submit a form titled "Managed Medical Assistance (MMA) Provider Service Network (PSN) Provider Ownership Interest and Disclosure Report," also known as Exhibit C-5. This exhibit contained the following directions:

Directions: List each PSN respondent owner included on the completed CMS-1513, Disclosure of Ownership and Control Interest Statement in Column (1). Include direct and indirect owners. In Column 2, specify the percent of indirect and direct ownership of each owner in the PSN respondent (see Item III on the CMS-1513 Detailed Instructions for information on direct and indirect ownership interest). In Column (3), indicate if the owner is currently a Medicaid provider (Yes or No). **Only MMA providers included in the legend below are considered providers for the purpose of meeting the MMA PSN ownership requirement pursuant to Section 409.962(13), Florida Statutes.** If the answer to Column (3) is yes, complete Columns (4), (5) and (6); otherwise, leave these columns blank. If completing Column (5), preface the number with either "L" for License Number or "M" for Medicaid identification number.

20. In Exhibit C-5's ownership disclosure table, a portion of which is reproduced below,^{9/} Prestige reported HCNF's ownership interest as follows:

Individual PSN Owner Names (1)	Percent of PSN Ownership (2)	Current Medicaid Provider? (Yes/No) (3)	Provider Type* (4)	Provider License # or Florida Medicaid ID Number (5)	Tax ID (6)
Health Choice Network of Florida	13.333%	Yes	GP		65-0504316
Azalea Health f/k/a Family Medical and Dental Centers	0.935%	Yes	FQ	M0295434-00	59-1792958
Borinquen Medical Centers of Miami Dade	1.190%	Yes	FQ	M0295540-00	59-1417397
Broward Community Family Health Center	0.017%	Yes	FQ	M6800271-00	59-3489664
Camillus Health Concern	0.509%	Yes	FQ	M6800025-00	65-0063921

*MMA Provider Type Legend (see Section 409.962(13), Florida Statutes):
 FP = Florida- licensed health care provider
 GP = group of affiliated providers
 PA= public agency or entity
 LF = Florida- licensed health care facility

21. In answering "Yes" to the question of whether HCNF is a Medicaid provider, Prestige did not tell the truth. In reality, as the evidence persuasively demonstrates, at no time relevant to this case was HCNF a health care provider, much less an enrolled Medicaid provider. HCNF is a nonprofit corporation organized under chapter 617, Florida Statutes. As described in its bylaws, HCNF's purposes are as follows:

[T]he Network's specific purposes shall be to operate and/or support clinical programs, to carry out certain community initiatives, and to perform certain management functions, including but not limited to, information systems and financial services, for the benefit of health centers as defined in Section 330 of the Public Health Service Act and similar community-based primary or behavioral health care organizations that

serve medically underserved and uninsured populations

22. Formed and governed by community medical and behavioral health centers, HCNF qualifies, under federal law, as a tax-exempt "501(c)(3) organization." Under its Articles of Incorporation, moreover, HCNF has chosen to be operated, at all times, "exclusively as a supporting organization within the meaning of Section 509(a)(3) of the [Internal Revenue] Code." As a section 509(a)(3) organization, HCNF is required to provide support services for the benefit of public agencies or private 501(c)(3) organizations. This it generally does for community mental health centers and FQHCs, which—unlike HCNF—directly provide health-care services.

23. According to HCNF's CEO Kevin Kearns, whose testimony on this point is credited as truthful, HCNF is a "fiscal intermediary services organization" ("FISO"). As defined in section 641.316(2)(b), Florida Statutes, a FISO is:

a person or entity that performs fiduciary or fiscal intermediary services to health care professionals who contract with health maintenance organizations other than a hospital licensed under chapter 395, an insurer licensed under chapter 624, a third-party administrator licensed under chapter 626, a prepaid limited health service organization licensed under chapter 636, a health maintenance organization licensed under this chapter, or a physician group practice as defined in s. 456.053(3)(h) which provides services under the scope of

licenses of the members of the group practice.

24. "Fiduciary or fiscal intermediary services" include:

[receiving and collecting reimbursements] on behalf of health care professionals for services rendered, patient and provider accounting, financial reporting and auditing, receipts and collections management, compensation and reimbursement disbursement services, or other related fiduciary services pursuant to health care professional contracts with health maintenance organizations.

§ 641.316(2)(a), Fla. Stat. FISOs must register with the Florida Office of Insurance Regulation. § 641.316(6), Fla. Stat.

25. HCNF is also a health center controlled network ("HCCN"). This term, as used by the Health Resources and Services Administration ("HRSA") of the U.S. Department of Health and Human Service, means:^{10/}

[a] group of safety net providers (a minimum of three collaborators/members) collaborating horizontally or vertically to improve access to care, enhance quality of care, and achieve cost efficiencies through the redesign of practices to integrate services, optimize patient outcomes, or negotiate managed care contracts on behalf of the participating members.

26. As a FISO and an HCCN, HCNF does not provide health-care services. Rather, HCNF provides back-office services to its members, each of whom is either a behavioral health care center or FQHC and, thus, a health care provider.^{11/} The back-

office services available to HCNF's members include financial services, information technology services, billing services, and centralized referral services. HCNF members pay annual dues for access to these services, and each of them pays additional fees to the corporation based upon the scope and volume of the services that HCNF renders to the individual member. In the abstract, HCNF's membership can reasonably be considered a "group of affiliated providers," for HCNF's members enjoy a mutually beneficial association under, and share a common interest in the continued operation of, the nonprofit corporation which is their jointly controlled service provider, i.e., HCNF.

27. Prestige, however, identified HCNF as a "GP," thereby signifying that HCNF (as opposed to its collective membership) is a "group of affiliated providers," that is, one of the health care "provider types" listed in Exhibit C-5's ownership disclosure table. Given that HCNF is not any type of provider, the designation of HCNF as a GP was of debatable accuracy,^{12/} but Prestige had claimed HCNF as a GP owner in previous filings with AHCA (unrelated to this procurement), and AHCA had not objected, so there was at least some historical precedent for such a characterization of HCNF.

28. In contrast, Prestige's statement in Exhibit C-5 that HCNF is a Medicaid provider was a material misrepresentation for

which no persuasive justification has been made. While the evidence fails to establish that Prestige intended to deceive AHCA, it does show that AHCA relied on Prestige's representations, including this one, which it accepted at face value. As AHCA explains in its Proposed Recommended Order, "Nothing in the ITN required AHCA to look beyond Prestige's certifications and disclosures in Exhibits C-3, C-4 and C-5 in determining Prestige's status as PSN."^{13/}

29. Thus, in making its decision to award Prestige the contract reserved for a PSN, AHCA did so in the mistaken belief that HCNF was a Medicaid provider, which in fact it is not. This is significant because if HCNF were a Medicaid provider, as AHCA thought, there would be no dispute over the treatment of HCNF's 13.333% interest in Prestige as "provider ownership" for the purpose of determining whether Prestige is majority-owned (over 50%) by a group of affiliated providers. As it is, there is no reason to consider non-provider HCNF's 13.333% interest for the purpose of meeting the PSN ownership requirement.

30. For reasons that will be more fully explained below in the Conclusions of Law, the undersigned determines as a matter of ultimate fact that Prestige is not a PSN for the purposes of the ITN because: (a) HCNF is not a health care provider; (b) HCNF is not a "group of affiliated providers" as that term is used in sections 409.912(4) and 409.962(13) and in Item No. 8

of ITN Exhibit C-3, nor, as a non-provider, can it be a member of such a group; and (c) when HCNF's 13.333% ownership interest is excluded from consideration, as it must be, Prestige is not majority-owned (over 50%) by a group of affiliated providers, as required by Item No. 8 of ITN Exhibit C-3.

31. Because Prestige is not a PSN for the purposes of the ITN, it is ineligible for the PSN award pursuant to the set-aside provided for in section 409.974(1)(k), Florida Statutes, which is what Prestige has tentatively won under AHCA's intended decision. AHCA's proposed action is, therefore, contrary to the plain and unambiguous language of the governing statutes and applicable ITN specifications. To the extent AHCA's proposed action is based upon interpretations of these statutes and specifications, such action is clearly erroneous.

32. The determination, as a matter of ultimate fact, that Prestige fails to meet the ITN's majority-ownership test and, hence, is not a PSN for purposes of this procurement provides a sufficient basis, without more, for concluding that AHCA should not proceed with the intended award. This makes it unnecessary to decide whether FTH is either in exclusive control of Prestige or, alternatively, the sole legal and beneficial owner of Prestige's shares, as Care Access contends; accordingly—and because a thorough discussion of the dispute over the nature and extent of FTH's respective ownership and controlling interests

might entail the disclosure of facts that Prestige considers confidential trade secrets—no further findings or conclusions on this issue will be made.^{14/}

33. Although the merits of Care Access's remaining protest grounds need not be decided either, the undersigned will address them in abbreviated fashion.

34. The Provider Network File. Each bidder was required to submit, as Exhibit E-3, a "Provider Network File" that contained a comprehensive listing of its proposed provider network. The ITN provided the following instructions for completing and submitting the Provider Network File:

Respondents shall submit both a printed hard copy and electronic version of the Provider Network File saved to CD. The electronic version of the Provider Network File shall be an Excel spreadsheet, and should adhere to the data specifications outlined below. The Agency will evaluate the Provider Network File using a Provider Network Assessment Tool

(Emphasis added.)

35. Addendum 2 to the ITN warned bidders as follows:

Respondents to the ITN shall utilize the Attachment E, Exhibits E-1 through E-5, as applicable. All respondents bidding on a Standard MMA Plan shall complete the following Exhibits to Attachment E: Exhibit E-1, Standard Submission Requirements and Evaluation Criteria; Exhibit E-2, Standard Quality Measurement Tool; and Exhibit E-3, Provider Network File. Failure to use the formats provided by the Agency or failure to properly complete any Exhibit may result in

a reduction of the score (to include an award of zero (0) points for the submission.)

(Emphasis added.) Neither Care Access nor any other vendor challenged this amendment to the ITN.

36. Prestige submitted its digital Provider Network File in the Portable Document Format ("PDF"), which is not supported in Microsoft Excel. Therefore, the AHCA evaluators were unable to extract data from the electronic version of Prestige's Provider Network File and needed to review the printed hard copy instead—a less efficient method of performing the task of evaluating Prestige's network.

37. Prestige's failure to submit the Provider Network File in the proper digital format did not give Prestige a competitive advantage over other bidders who strictly complied with the electronic filing requirements. A list of Prestige's providers was, after all, submitted (as required) in a printed hard copy and thus available for review. In addition, AHCA's evaluators deducted points from Prestige's score for the mistake of submitting an incompatible electronic file, a penalty which placed Prestige at a competitive disadvantage relative to compliant bidders. In giving Prestige zero points for evaluation criteria related to the Provider Network File, the evaluators took action consistent with the ITN's instructions.

38. AHCA determined, as a matter of ultimate fact, that Prestige's submission of an electronic PDF document containing its provider list, rather than an Excel-compatible file, was a minor irregularity, not a material deviation. This determination, the undersigned finds, was not clearly erroneous.

39. AHCA's decision to waive the minor irregularity is entitled to great deference and should be upheld unless it was arbitrary or capricious. The undersigned cannot say that waiving the technical deficiency was illogical, despotic, thoughtless, or otherwise an abuse of discretion. Therefore, the intended award should not be rescinded based upon Prestige's noncompliance with the electronic filing requirements.

40. Collusion. The ITN contained three separate provisions prohibiting collusion and requiring the bidders to independently prepare their responses. In Attachment A, the ITN provided as follows:

9. Respondent's Representation and Authorization.

In submitting a response, each respondent understands, represents, and acknowledges the following (if the respondent cannot so certify to any of following, the respondent shall submit with its response a written explanation of why it cannot do so).

* * *

The submission is made in good faith and not pursuant to any agreement or discussion with, or inducement from, any firm or person

to submit a complementary or other noncompetitive response.

* * *

The respondent has made a diligent inquiry of its employees and agents responsible for preparing, approving, or submitting the response, and has been advised by each of them that he or she has not participated in any communication, consultation, discussion, agreement, collusion, act or other conduct inconsistent with any of the statements and representations made in the response.

41. In Attachment C, the ITN provided these instructions for preparing a response:

Independent Preparation of Response: A respondent shall not, directly or indirectly, collude, consult, communicate or agree with any other respondent as to any matter related to the response each is submitting. Additionally, a respondent shall not induce any other respondent to submit or not to submit a response.

42. Finally, the ITN required bidders to sign a "Non-Collusion Certification," which provided as follows:

I hereby certify that all persons, companies, or parties interested in the response as principals are named therein, that the response is made without collusion with any other person, persons, company, or parties submitting a response.

43. In applying the foregoing anti-collusion provisions, consideration must be given to section 409.966(3)(b), Florida Statutes, which governs the instant procurement and provides as follows:

An eligible plan must disclose any business relationship it has with any other eligible plan that responds to the invitation to negotiate. The agency may not select plans in the same region for the same managed care program that have a business relationship with each other. Failure to disclose any business relationship shall result in disqualification from participation in any region for the first full contract period after the discovery of the business relationship by the agency. For the purpose of this section, "business relationship" means an ownership or controlling interest, an affiliate or subsidiary relationship, a common parent, or any mutual interest in any limited partnership, limited liability partnership, limited liability company, or other entity or business association, including all wholly or partially owned subsidiaries, majority-owned subsidiaries, parent companies, or affiliates of such entities, business associations, or other enterprises, that exists for the purpose of making a profit.

(Emphasis added.)

44. It is not surprising that, in view of section 409.966(3)(b)—which practically requires potential bidders having a business relationship with each other to coordinate in some fashion so as to avoid an intra-regional competition that would be at best a zero-sum game between them—several vendors sought clarification of the anti-collusion provisions during the pre-bid question-and-answer process. Of interest are the following questions:

6. Can entities which have some common ownership, share common management or have Board of Directors that overlap, strategize

and determine [through] communications and discussion which region under the SMMC ITN is appropriate for each such entity to respond to as a bidder without violating the prohibition against "inducement" set forth in the SMMC ITN?

* * *

13. Does this section apply to respondents who are affiliates and who are preparing responses in different regions?

* * *

23. How can entities which share some common ownership or are otherwise related in some manner AND who are responding to the SMMC ITN in separate and distinct regions collaborate, communicate, consult and strategize on each's respective response to the SMMC ITN for the applicable region without violating the requirement of "independent preparation of response" as set forth in the SMMC ITN?

AHCA answered each of these questions with the same response:

"Each Regional ITN is a separate procurement, the specifications of which apply to that region." This answer was made part of the ITN through Addendum 2.

45. What AHCA meant by this, the evidence shows, is that the anti-collusion provisions were intended to apply only to bidders competing against each other within a particular region. While there might be other reasonable interpretations of the ITN's anti-collusion specifications, AHCA's is within the range of permissible interpretations and, thus, not clearly erroneous.

Indeed, a stricter interpretation might have discouraged affiliated companies from competing.^{15/}

46. FTH did not submit a bid in response to the ITN. Pursuant to AHCA's interpretation of the ITN's anti-collusion specifications—an interpretation which no one protested upon its publication in Addendum 2 to the ITN—Prestige and FTH were free to communicate with each other about one's bid in any region, such as Region 11, where the two would not be competing head-to-head. AHCA's proposed action should not be set aside based upon the objection that Prestige violated the ITN's anti-collusion provisions by communicating with FTH.

47. Cost Proposals. Care Access objects to AHCA's refusal to allow a bidder to achieve an advantage over competitors by offering a lower price. The evidence shows that, after comparing and evaluating the price proposals submitted by each vendor for the region, AHCA developed a common base rate, which was presented to the bidders invited to participate in negotiations. This rate (\$366.66) was higher than Care Access's initial offer (\$317.46). During negotiations, Care Access acceded to AHCA's proposed rate, apparently because there was nothing to be gained by offering a lower price, as it had been willing to do.

48. AHCA's establishment of a common base rate which a bidder willing to accept less was not allowed to beat for

competitive advantage conformed to the answer AHCA had given in response to a pre-bid question, which had been published in Addendum 2 to the ITN. The question was: "Will the state consider plan specific reimbursement rates or will there be a common rate negotiated among the awarded plans within a region?" AHCA answered as follows: "The Agency intends to negotiate common base rates for each region." No potential bidder protested this response, which became part of the ITN.

49. It is determined as a matter of ultimate fact that the procedure used by AHCA with respect to the common rate was not contrary to the terms of the ITN, but rather was consistent therewith. Consequently, AHCA's intended action should not be disturbed based upon Care Access's objection to use of a common base rate.

CONCLUSIONS OF LAW

50. DOAH has personal and subject matter jurisdiction in this proceeding pursuant to sections 120.569, 120.57(1), and 120.57(3), Florida Statutes, and the parties have standing.

51. Pursuant to section 120.57(3)(f), Florida Statutes, the burden of proof rests with the party opposing the proposed agency action, here Care Access. See State Contracting & Eng'g Corp. v. Dep't of Transp., 709 So. 2d 607, 609 (Fla. 1st DCA 1998). Care Access must sustain its burden of proof by a

preponderance of the evidence. Dep't of Transp. v. J.W.C. Co., Inc., 396 So. 2d 778, 787 (Fla. 1st DCA 1981).

52. Section 120.57(3)(f), Florida Statutes, spells out the rules of decision applicable in bid protests. In pertinent part, the statute provides:

In a competitive-procurement protest, other than a rejection of all bids, the administrative law judge shall conduct a de novo proceeding to determine whether the agency's proposed action is contrary to the agency's governing statutes, the agency's rules or policies, or the bid or proposal specifications. The standard of proof for such proceedings shall be whether the proposed agency action was clearly erroneous, contrary to competition, arbitrary, or capricious.

53. The First District Court of Appeal has construed the term "de novo proceeding," as used in section 120.57(3)(f), to "describe a form of intra-agency review. The judge may receive evidence, as with any formal hearing under section 120.57(1), but the object of the proceeding is to evaluate the action taken by the agency." State Contracting, 709 So. 2d at 609.

54. In framing the ultimate issue to be decided in this de novo proceeding as being "whether the agency's proposed action is contrary to the agency's governing statutes, the agency's rules or policies, or the bid or proposal specifications," the statute effectively establishes a *standard of conduct* for the agency, which is that, in soliciting, evaluating, and accepting

bids or proposals, the agency must obey its governing statutes, rules, and the project specifications. If the agency breaches this standard of conduct, its proposed action is subject to reversal in a protest proceeding.

55. Consequently, the party protesting the intended award must identify and prove, by the greater weight of the evidence, a specific instance or instances where the agency's conduct in taking its proposed action was either: (a) contrary to the agency's governing statutes; (b) contrary to the agency's rules or policies; or (c) contrary to the bid or proposal specifications.

56. It is not sufficient, however, for the protester to prove merely that the agency violated the general standard of conduct. By virtue of the applicable standards of "proof," which are best understood as standards of review,¹⁶ / the protester additionally must establish that the agency's misstep was:

(a) clearly erroneous; (b) contrary to competition; or (c) an abuse of discretion.

57. The three review standards mentioned in the preceding paragraph are markedly different from one another. The abuse of discretion standard, for example, is more deferential (or narrower) than the clearly erroneous standard. The bid protest review process thus necessarily entails a decision or decisions

regarding which of the several standards of review to use in evaluating a particular action. To do this requires that the meaning and applicability of each standard be carefully considered.

58. The clearly erroneous standard is generally applied in reviewing a lower tribunal's findings of fact. In Anderson v. City of Bessemer City, N.C., 470 U.S. 564, 573-74, 105 S. Ct. 1504, 1511, 84 L. Ed. 2d 518, 528 (1985), the United States Supreme Court expounded on the meaning of the phrase "clearly erroneous," explaining:

Although the meaning of the phrase "clearly erroneous" is not immediately apparent, certain general principles governing the exercise of the appellate court's power to overturn findings of a [trial] court may be derived from our cases. The foremost of these principles . . . is that "[a] finding is 'clearly erroneous' when although there is evidence to support it, the reviewing court on the entire evidence is left with the definite and firm conviction that a mistake has been committed." This standard plainly does not entitle a reviewing court to reverse the finding of the trier of fact simply because it is convinced that it would have decided the case differently. The reviewing court oversteps the bounds of its duty . . . if it undertakes to duplicate the role of the lower court. "In applying the clearly erroneous standard to the findings of a [trial] court sitting without a jury, appellate courts must constantly have in mind that their function is not to decide factual issues *de novo*." If the [trial] court's account of the evidence is plausible in light of the record viewed in

its entirety, the court of appeals may not reverse it even though convinced that had it been sitting as the trier of fact, it would have weighed the evidence differently. Where there are two permissible views of the evidence, the factfinder's choice between them cannot be clearly erroneous. . . .

(Citations omitted) (emphasis added).

59. The Florida Supreme Court has used somewhat different language to give this standard essentially the same meaning:

A finding of fact by the trial court in a non-jury case will not be set aside on review unless there is no substantial evidence to sustain it, unless it is clearly against the weight of the evidence, or unless it was induced by an erroneous view of the law. A finding which rests on conclusions drawn from undisputed evidence, rather than on conflicts in the testimony, does not carry with it the same conclusiveness as a finding resting on probative disputed facts, but is rather in the nature of a legal conclusion. . . . When the appellate court is convinced that an express or inferential finding of the trial court is without support of any substantial evidence, is clearly against the weight of the evidence or that the trial court has misapplied the law to the established facts, then the decision is 'clearly erroneous' and the appellate court will reverse because the trial court has 'failed to give legal effect to the evidence' in its entirety.

Holland v. Gross, 89 So. 2d 255, 258 (Fla. 1956) (citation omitted).

60. Because administrative law judges are the triers of fact charged with resolving disputed issues of material fact

based upon the evidence presented at hearing, and because bid protests are fundamentally de novo proceedings, the undersigned is not required to defer to the letting authority in regard to any findings of objective historical fact that might have been made in the run-up to preliminary agency action. It is exclusively the administrative law judge's responsibility, as the trier of fact, to ascertain from the competent, substantial evidence in the record what actually happened in the past or what reality presently exists, as if no findings previously had been made.

61. If, however, the challenged agency action involves an ultimate factual determination—for example, an agency's conclusion that a proposal's departure from the project specifications was a minor irregularity as opposed to a material deviation—then some deference is in order, according to the clearly erroneous standard of review.^{17/} To prevail on an objection to an ultimate finding, therefore, the protester must substantially undermine the factual predicate for the agency's conclusion or convince the judge that a defect in the agency's logic unequivocally led to a mistake.

62. There is another species of agency action that also is entitled to review under the clearly erroneous standard: interpretations of statutes for whose administration the agency

is responsible, and interpretations of the agency's own rules. See State Contracting & Eng'g Corp. v. Dep't of Transp., 709 So. 2d 607, 610 (Fla. 1st DCA 1998). In deference to the agency's expertise, such interpretations will not be overturned unless clearly erroneous. Id.^{18/}

63. This means that if the protester objects to the proposed agency action on the ground that it violates either a governing statute within the agency's substantive jurisdiction or the agency's own rule, and if, further, the validity of the objection turns on the meaning of the subject statute or rule, then the agency's interpretation should be accorded deference; the challenged action should stand unless the agency's interpretation is clearly erroneous (assuming the agency acted in accordance therewith).

64. The same standard of review also applies, in a protest following the announcement of an intended award, with regard to preliminary agency action taken upon the agency's interpretation of the project specifications—but for a reason other than deference to agency expertise. Section 120.57(3)(b), Florida Statutes, provides a remedy for badly written or ambiguous specifications: they may be protested within 72 hours after the posting of the specifications. The failure to avail oneself of this remedy results in a waiver of the right to complain about the specifications per se.

65. Consequently, if the dispute in a protest challenging a proposed award turns on the interpretation of an ambiguous, vague, or unreasonable specification, which could have been corrected or clarified prior to acceptance of the bids or proposals had a timely specifications protest been brought, and if the agency has acted thereafter in accordance with a permissible interpretation of the specification (i.e., one that is not clearly erroneous), then the agency's intended action should be upheld—not out of deference to agency expertise, but as a result of the protester's waiver of the right to seek relief based on a faulty specification.^{19/}

66. The statute requires that agency action (in violation of the applicable standard of conduct) which is "arbitrary, or capricious" be set aside. The phrase "arbitrary, or capricious" can be equated with the abuse of discretion standard because the concepts are practically indistinguishable—and because use of the term "discretion" serves as a useful reminder regarding the kind of agency action reviewable under this highly deferential standard.

67. It has been observed that an arbitrary decision is one that is not supported by facts or logic, or is despotic. Agrico Chemical Co. v. Dep't of Env'tl. Reg., 365 So. 2d 759, 763 (Fla. 1st DCA 1978), cert. denied, 376 So. 2d 74 (Fla. 1979). Thus, under the arbitrary or capricious standard, "an agency is to be

subjected only to the most rudimentary command of rationality. The reviewing court is not authorized to examine whether the agency's empirical conclusions have support in substantial evidence." Adam Smith Enters., Inc. v. Dep't of Env'tl. Reg., 553 So. 2d 1260, 1273 (Fla. 1st DCA 1989). Nevertheless,

the reviewing court must consider whether the agency: (1) has considered all relevant factors; (2) has given actual, good faith consideration to those factors; and (3) has used reason rather than whim to progress from consideration of each of these factors to its final decision.

Id.

68. The second district framed the "arbitrary or capricious" review standard in these terms: "If an administrative decision is justifiable under any analysis that a reasonable person would use to reach a decision of similar importance, it would seem that the decision is neither arbitrary nor capricious." Dravo Basic Materials Co., Inc. v. Dep't of Transp., 602 So. 2d 632, 634 n.3 (Fla. 2d DCA 1992). As the court observed, this "is usually a fact-intensive determination." Id. at 634.

69. Compare the foregoing "arbitrary or capricious" analysis with the test for reviewing discretionary decisions:

"Discretion, in this sense, is abused when the judicial action is arbitrary, fanciful, or unreasonable, which is another way of saying that discretion is abused only where no reasonable man would take the view

adopted by the trial court. If reasonable men could differ as to the propriety of the action taken by the trial court, then it cannot be said that the trial court abused its discretion."

Canakaris v. Canakaris, 382 So. 2d 1197, 1203 (Fla. 1980), quoting Delno v. Market St. Ry. Co., 124 F.2d 965, 967 (9th Cir. 1942). Further,

[t]he trial court's discretionary power is subject only to the test of reasonableness, but that test requires a determination of whether there is logic and justification for the result. The trial courts' discretionary power was never intended to be exercised in accordance with whim or caprice of the judge nor in an inconsistent manner. Judges dealing with cases essentially alike should reach the same result. Different results reached from substantially the same facts comport with neither logic nor reasonableness.

Canakaris, 382 So. 2d at 1203.

70. Whether the standard is called "arbitrary or capricious" or "abuse of discretion," the scope of review, which demands maximum deference, is the same. Clearly, then, the narrow "arbitrary or capricious" standard of review cannot properly be applied in evaluating all agency actions that might be challenged in a bid protest; rather, this highly deferential standard appropriately applies only to those decisions which are committed to the agency's discretion.

71. Therefore, where the protester objects to agency action that entails the exercise of discretion, but only in such

instances, the objection cannot be sustained unless the agency abused its discretion, i.e., acted arbitrarily or capriciously.

72. The third standard of review articulated in section 120.57(3)(f) is unique to bid protests. The "contrary to competition" test is a catch-all which applies to agency actions that do not turn on the interpretation of a statute or rule, do not involve the exercise of discretion, and do not depend upon (or amount to) a determination of ultimate fact.

73. Although the contrary to competition standard, being unique to bid protests, is less well defined than the other review standards, the undersigned concludes that the set of proscribed actions should include, at a minimum, those which: (a) create the appearance of and opportunity for favoritism; (b) erode public confidence that contracts are awarded equitably and economically; (c) cause the procurement process to be genuinely unfair or unreasonably exclusive; or (d) are unethical, dishonest, illegal, or fraudulent. See, e.g., R. N. Expertise, Inc. v. Miami-Dade Cnty. Sch. Bd., Case No. 01-2663BID, 2002 Fla. Div. Adm. Hear. LEXIS 163, *58 (Fla. DOAH Feb. 4, 2002); see also E-Builder v. Miami-Dade Cnty. Sch. Bd., Case No. 03-1581BID, 2003 WL 22347989, *10 (Fla. DOAH Oct. 10, 2003).

74. Turning to the merits of this case, Care Access's contention that Prestige is not a PSN turns on the statutory

definitions of PSN, which are located in sections 409.912(4) and 409.962(13), Florida Statutes, as augmented by the ITN's description of such an entity, which is set forth in Item No. 8 of Exhibit C-3. AHCA's interpretation of these provisions is entitled to deference, for reasons explained above.

75. The relevant language of these provisions, however, is clear and unambiguous, and needs only to be applied, not construed.^{20/} To the extent AHCA's understanding of what is necessary to qualify as a PSN differs from or is inconsistent with the conclusions which follow, AHCA's interpretation or proposed implementation of the pertinent statutory and ITN provisions has been rejected as clearly erroneous.

76. Taken together, the applicable definitions make the existence of a PSN dependent upon the combination of four essential components, namely:

- Provider Management. A provider service network is a network established or organized and operated by either: (a) a health care provider, or a public agency or entity that delivers health services ("Managing Provider"); or (b) a managerial group of affiliated health care providers ("MGAP").
- Network Composition. A PSN's Managing Provider or MGAP, whichever is applicable, directly provides a substantial proportion of the health care items and services delineated under a contract with AHCA.
- Risk-Sharing Arrangements. A PSN may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a

prospective basis for the provision of basic health services by the physicians, by other health professionals, or through the institutions.

- Provider Control and Financial Interest. The Managing Provider or MGAP, as the case may be, must (a) own a controlling interest in the PSN entity, (b) have a controlling interest in the governing body of the PSN entity, and (c) own a majority (more than 50%) of the PSN entity.

77. According to section 409.962(13), the term "provider," for the purpose of defining a PSN, includes "Florida-licensed health care professionals or licensed health care facilities, federally qualified health care centers, and home health care agencies." In addition, section 409.901(17) defines the term "provider" to mean "a person or entity that has a Medicaid provider agreement in effect with the agency and [who] is in good standing with the agency." A Medicaid provider agreement is "a contract between the agency and a provider for the provision of services or goods, or both, to Medicaid recipients pursuant to Medicaid." § 409.901(18), Fla. Stat.

78. Thus, to be a "provider" as that term is used in the definition of PSN, it is necessary for the person or entity claiming such status to be an enrolled Medicaid provider. This means, conversely, that a person or entity which is not an enrolled Medicaid provider likewise cannot be, for that reason alone, a "provider" for the purpose of defining a PSN, even if

such person or entity is a licensed health-care professional or facility.

79. Further, because of the Network Composition requirement, a Managing Provider cannot merely be a passive investor in the PSN. Rather, it must deliver medical services directly to Medicaid recipients assigned to the PSN. When the PSN is operated by an MGAP instead of a Managing Provider, the members of the MGAP must deliver medical services directly to Medicaid recipients assigned to the PSN. Thus, the Managing Provider, or each of the Medicaid providers who make up the MGAP, as the case may be, must be a "Network Provider" for the PSN. The PSN may deliver medical services through Network Providers who are not the Managing Provider or members of the MGAP, as the case may be, so long as the Managing Provider or MGAP, whichever is applicable, provides a "substantial proportion" of the services that are the obligation of the PSN under its contract with AHCA.

80. In addressing the Provider Management requirement, AHCA and Prestige subtly alter the meaning of the statutory language, asserting that a network is a PSN if it is operated by "provider owners," which can consist of "providers or groups of affiliated providers." As a careful review shows, however, this is not precisely what the statutes and ITN say. Rather, the statutes and ITN are clear that a PSN must be operated either by

a single Managing Provider or, if more than one provider, by a single MGAP. There is no ambiguity in the relevant language on this point and hence no room for interpretation.

81. At first blush this might seem like pedantic quibbling. But fudging the requirement that there be only one Managing Provider or, alternatively, one MGAP per PSN is what permits AHCA and Prestige to advance an argument that otherwise could not get off the ground, namely that HCNF "qualifies" as a group of affiliated providers—and thus as a "provider owner"—because, although HCNF itself is not an enrolled Medicaid provider, all of its members are providers. Under AHCA and Prestige's theory, in other words, an entity need not be a provider to be designated a "provider owner," so long as the entity "qualifies" as a group of affiliated providers, which they claim HCNF does based on its membership.

82. To be sure, as AHCA and Prestige use the term, a "provider owner" could be a Managing Provider or a member of the MGAP responsible for operating a PSN. To that extent, the coinage is not controversial. The nonstatutory nomenclature, however, insinuates into the discussion the dubious idea that an entity which is an owner but not a provider can be considered a "provider owner."^{21/}

83. Identifying non-provider HCNF as a "group of affiliated health care providers"—"provider owner"—or, "non-

provider provider-group provider owner" ("NPPGPO") for short— does not, however, entirely solve the problem that HCNF's non-provider status creates for AHCA and Prestige. This is because even if such a thing as an NPPGPO exists, and if, further, HCNF is the archetype of such an entity, the fact remains that HCNF is not the only "provider owner" of Prestige; it is one of many "provider owners." As mentioned above, the statutes clearly require that a PSN having multiple provider-managers be operated, not by groups (plural) of affiliated providers, but by a group (singular) of affiliated providers.

84. AHCA and Prestige do not argue otherwise; they simply assume, without explaining why it should be, that the term "group of affiliated health care providers" describes one type of qualifying "provider owner," as opposed to the entire group of affiliated "provider owners" responsible for a PSN's operation, i.e., the MGAP. Reducing the category named "group of affiliated health care providers" to the definition of an acceptable type of "provider owner" enables AHCA and Prestige to use "provider owners" to denote the set of all investors considered providers for the purpose of meeting the PSN ownership requirement. Thus, as AHCA and Prestige use the term, "provider owners" is a universal category containing within it, not only individual provider owners, but also, as a subset or subsets, such groups of affiliated providers as NPPGPOs.

85. Their view, however, must be rejected because it inverts the idea behind the term "group of affiliated health care providers," which as used in the statutes unambiguously means that particular group comprising the universe of a PSN's affiliated "provider owners," i.e., the set of all providers affiliated through their joint responsibility for operating the PSN. Clearly, in prescribing one MGAP, at most, per PSN, the statutes require that all of the providers making up the MGAP be affiliated with one another through their common interest in operating the PSN. Thus, the category denoted by the term "group of affiliated health care providers" responsible for operating a PSN, being universal, logically cannot include autonomous "subgroups" of affiliated providers whose respective associations are discrete, exclusive, and unrelated to the PSN, for not all members of such a "subgroup" would belong to the prime group: the "subgroup," accordingly, must actually be a separate category.

86. In arguing that HCNF is an NPPGPO, AHCA and Prestige have taken the term "group of affiliated health care providers" out of its relevant statutory context to exploit the fact that, when employed as a generic descriptor, this label can be placed on quite different types of provider-populated groups—collections of providers, that is, which might reasonably be viewed as a group of affiliated providers for one purpose, but

not necessarily for other purposes, such as determining the composition of a PSN's MGAP.

87. One common type of provider group, for example, comprises physicians having similar or related specialties—say, anesthesiologists, dermatologists, or radiologists—who form a group practice, which delivers health-care services through the affiliated practitioners. Regardless of its particular form of organization, e.g., partnership or corporation, a group practice of this nature might become a Medicaid enrolled group ("MEG"), with its own Medicaid number distinct from that of any of the individual practitioners in the group. A group practice, in other words, can be a "provider" in its own right.^{22/}

88. In ordinary conversation, the members of a group practice, including a MEG, could be referred to, without confusion, as a group of affiliated providers. In the present discussion, however, such usage can create confusion. Therefore, in this Recommended Order, a group of providers who have affiliated to form a MEG which provides services to Medicaid recipients will be called "Joint Practitioners."

89. A group of providers could affiliate with one another for purposes other than the delivery of health-care services. For example, a group of physicians could form an entity, e.g., a general partnership, whose business would be to purchase and manage, say, a professional football team. No one, however,

would seriously assert that a football team is, or could be deemed to be, a provider, even if it were owned by a group of doctors. *A provider-owned business is not a provider merely because the business is owned by providers.* For ease of reference, therefore, any entity which is not a MEG or other institutional Medicaid provider will be referred to herein as an "Enterprise."

90. In everyday discourse, a group of physicians who have invested together in an Enterprise could be referred to, for that reason, as a group of affiliated providers; for clarity's sake, a group of providers who are affiliated through joint ownership or control of an Enterprise will herein be called "Joint Stakeholders."

91. As the instant case makes clear, a group of providers can affiliate with one another for the purposes of establishing and operating a PSN. To be a member of such a group, one must be a provider, because the inclusion of non-providers would belie one of the group's defining attributes, i.e., that it is a set of providers.^{23/} A "provider" for this purpose could be an individual or institutional provider or a MEG, but whichever it is, the member must, at bottom, be a provider. A group of providers who have affiliated for the purpose of operating a PSN will continue to be called an MGAP, using the previously introduced acronym.

92. At this point, a hypothetical situation might be helpful to illustrate the relevant differences between the various types of groups identified above. Imagine three licensed physicians—Adams, Jones, and Smith—each of whom specializes in urology and has become associated with the other two doctors as a shareholder of a closely held corporation which does business as Urology Associates, a group medical practice. Urology Associates is a MEG having its own Medicaid number, and Drs. Adams, Jones, and Smith, respectively, are enrolled as individual Medicaid providers with Medicaid numbers of their own. As Joint Practitioners, the three urologists form a group of affiliated providers, in one sense of that description.

93. Now suppose Drs. Adams, Jones, and Smith decide to purchase a corporation—Pub, Inc.—whose business is to own and operate a local sports bar. Upon closing the sale, the three doctors each own one-third of the shares of Pub, Inc. Yet Pub, Inc., is not, obviously, a MEG, and the fact that the corporation is 100% owned by providers does not make it a provider—a point that should also be obvious. Pub, Inc., is, instead, plainly an Enterprise. As the owners of Pub, Inc., Drs. Adams, Jones, and Smith could rationally be called a group of affiliated providers of a sort, for they constitute a group, are affiliated as Pub, Inc., shareholders, and are all

providers. More specifically, as the owners of Pub, Inc., Drs. Adams, Jones, and Smith are Joint Stakeholders.

94. Clearly, however, the physician investors are not, in their respective capacities as Pub, Inc., shareholders, Joint Practitioners—a statement that is true even though the same three providers are Joint Practitioners, in a separate context, by virtue of being owners and employees of Urology Associates. Equally plain is the fact that Pub, Inc., despite being owned by a group of affiliated providers, cannot reasonably be described as a group of affiliated providers, for the corporation itself is neither a group nor a provider.

95. Imagine, finally, that Urology Associates acquires a 10% equity interest in Superior PSN, LLC, a provider service network in which Dr. Adams personally takes a 5% interest, but in which Drs. Jones and Smith decline to invest. Urology Associates (a Medicaid provider) and Dr. Adams (a Medicaid provider) associate themselves with other providers to form an MGAP responsible for Superior's operation. Collectively, the members of Superior's MGAP own 75% of the entity's shares. The remaining equity is owned by various non-providers, including Pub, Inc., which holds a 5% interest. Drs. Adams, Jones, and Smith, doing business as Urology Associates, are Network Providers for Superior.

96. As should be clear, Pub, Inc., cannot be part of Superior's MGAP. This is so because, even though Pub, Inc., is owned exclusively by a group of providers, Pub, Inc., is not itself a provider. This is true, moreover, notwithstanding the facts that Drs. Adams, Jones, and Smith, as Joint Stakeholders in Pub, Inc., constitute a group of affiliated providers in that sense; and that Dr. Adams himself is a member of Superior's MGAP. Calling Pub, Inc., a non-provider provider-group provider-owner of Superior would be consistent with (if not compelled by the thinking behind) AHCA and Prestige's contention that HCNF is an NPPGPO of Prestige—and also plainly unreasonable, given that a sports bar has nothing to do with health care.

97. HCNF is akin to the imaginary Pub, Inc., because, as the evidence in this case establishes persuasively, the nonprofit corporate entity known as HCNF is neither a licensed facility nor a practitioner, and it is not a group practice. Significantly, HCNF is not a MEG having its own Medicaid provider number. Consequently, like Pub, Inc., HCNF is an Enterprise, i.e., an entity which is not a MEG or other type of institutional Medicaid provider.

98. Therefore, HCNF's members, qua HCNF members, are Joint Stakeholders analogous to the fictional Drs. Adams, Jones, and Smith, who, in their respective capacities as shareholders of

Pub, Inc., are Joint Stakeholders, too. Although they might happen to be providers themselves, the members or owners of an Enterprise, such as HCNF's members (or Pub, Inc.'s shareholders), are not Joint Practitioners merely because of their common interest and affiliation as Joint Stakeholders—a point that remains true even though the same providers might be Joint Practitioners by virtue of a separate and independent affiliation, as is the case with the three make-believe physicians who practice together as Urology Associates.

99. Ultimately, because HCNF is not a MEG or other institutional Medicaid provider, the facts that HCNF's members might reasonably be described as a group of affiliated providers due to their common association with HCNF, and that some HCNF members own equity in Prestige, are irrelevant for the purpose of meeting the PSN ownership requirement; these facts simply do not change the relevant fact that HCNF is not a provider. Moreover, because HCNF is not a provider, it cannot be a member of Prestige's MGAP because, to repeat for emphasis, an MGAP responsible for operating a PSN must comprise providers, and only providers.

100. As a discrete entity having its own independent legal existence, non-provider HCNF, the corporate owner of 13.333% of Prestige, is not a group in any sense of the word. As a means of circumventing this reality, calling HCNF a non-provider

provider-group provider-owner—while perhaps marginally less unreasonable than deeming Pub, Inc., an NPPGPO, given that HCNF at least does business in the field of health care—is unpersuasive; the term is obviously a misnomer. Just like Pub, Inc., whose identity is separate from that of its shareholders, HCNF is a corporate entity distinct from its membership. HCNF cannot assimilate the attributes of its members, as if by osmosis, and thereby acquire sufficient provider-like properties to be deemed a "provider owner," any more than a sports bar being purchased by a group of providers would turn into a quasi-provider upon the transaction's closing due to the attributes of its new owners. The corporate veil is not a semipermeable membrane.

101. In arguing that HCNF is a group of affiliated providers, however, AHCA and Prestige invite the undersigned, at least implicitly, to peer through the corporate veil, as if HCNF were nothing more than the set of its members, its corporate identity a trivial technicality. Their reasoning seems to be that, because HCNF's members are, as such, affiliated providers, it is reasonable to view HCNF as a group of affiliated providers, as though HCNF were a kind of group practice, despite the fact that HCNF is not itself a group practice or other type of provider. This is not a persuasive argument, and thus the invitation to ignore the corporate veil must be declined.

102. Indeed, the undersigned does not have jurisdiction to pierce a corporate veil,^{24/} even if it were appropriate to do so under these circumstances, which it is not. Having elected to organize HCNF as a nonprofit corporation, presumably to enjoy the benefits of operating through such an entity, the members of HCNF themselves could not casually disregard the corporate form to avoid a burden attending to that legal identity. There is, therefore, no justification for allowing AHCA and Prestige—neither of which is a member of HCNF—to disregard HCNF's corporate identity simply because it suits them to do so.

103. The bottom line is that the Joint Stakeholders of HCNF are not, as a result of that particular affiliation, members of Prestige's MGAP, even though HCNF is a partial owner of Prestige. Membership in HCNF does not preclude membership in Prestige's MGAP, of course. Indeed, some (but not all) of HCNF's members are equity owners of Prestige and, on that basis, are affiliated with other providers who likewise own shares in Prestige. Consequently, while some HCNF members, by virtue of their respective ownership interests in Prestige, also happen to be members of the MGAP responsible for Prestige's operation, HCNF's members, as a group, are not the MGAP responsible for Prestige's operation, nor, as separate providers, are they all members of the MGAP responsible for Prestige's operation.

104. In sum, HCNF is an owner of Prestige but not a "provider owner." HCNF is not, and cannot reasonably be described as or deemed, a "group of affiliated providers" for the purposes of sections 409.912(4)(d)4. and 409.962(13). It must be concluded—indeed, there is no reasonable or logical conclusion other than—that HCNF is neither the "group of affiliated providers" responsible for operating Prestige nor a member of such group.

105. Accordingly, HCNF's 13.333% ownership interest in Prestige—which incidentally is a corporate asset that the nonprofit's members do not even indirectly own—cannot be counted toward the provider ownership of the entity.

106. When HCNF's 13.333% stake is excluded from the computation, the percentage of Prestige's equity currently held by providers is less than 50%. That being the case, Prestige does not satisfy the Provider Control and Financial Interest element of the PSN definition. For purposes of the ITN, therefore, Prestige is not a PSN.

107. Based on the findings of fact set forth above, as well as the foregoing legal conclusions, the undersigned concludes that AHCA's intended award of the contract reserved for a PSN in Region 11 to Prestige is contrary to the plain language of the governing statutes and applicable ITN specifications. For that

reason, the proposed award is clearly erroneous and should be rescinded.

108. As for the remaining protest grounds, not much more needs to be said. Regarding the allegation that Prestige's bid was nonresponsive, it has long been recognized that "although a bid containing a material variance is unacceptable, not every deviation from the invitation to bid is material. [A deviation] is material if it gives the bidder a substantial advantage over the other bidders and thereby restricts or stifles competition." Tropabest Foods, Inc. v. Dep't of Gen. Servs., 493 So. 2d 50, 52 (Fla. 1st DCA 1986). "The test for measuring whether a deviation in a bid is sufficiently material to destroy its competitive character is whether the variation affects the amount of the bid by giving the bidder an advantage or benefit not enjoyed by other bidders." Harry Pepper & Assocs., Inc. v. City of Cape Coral, 352 So. 2d 1190, 1193 (Fla. 2d DCA 1977).

109. In addition to the foregoing rules, courts have considered the following criteria in determining whether a variance is material and hence nonwaivable:

[F]irst, whether the effect of a waiver would be to deprive the municipality of its assurance that the contract will be entered into, performed and guaranteed according to its specified requirements, and second, whether it is of such a nature that its waiver would adversely affect competitive bidding by placing a bidder in a position of advantage over other bidders or by otherwise

undermining the necessary common standard of competition.

[S]ometimes it is said that a bid may be rejected or disregarded if there is a material variance between the bid and the advertisement. A minor variance, however, will not invalidate the bid. In this context a variance is material if it gives the bidder a substantial advantage over the other bidders, and thereby restricts or stifles competition.

Robinson Elec. Co. v. Dade Cnty., 417 So. 2d 1032, 1034 (Fla. 3d DCA 1982), quoting 10 McQuillan, Municipal Corporations § 29.65 (3d ed. rev. 1981) (footnotes omitted).

110. In this instance, there is no dispute that Prestige's failure to follow the electronic filing requirements in submitting its Provider Network File constituted an irregularity. Prestige, however, did not secure a substantial competitive advantage from the error; to the contrary, its noncompliance, which resulted in a loss of points, placed Prestige at a disadvantage. In awarding zero points for the criteria relating to the Provider Network File, AHCA imposed the penalty prescribed in the ITN for such a deficiency.

111. The undersigned concludes, therefore, that AHCA did not unequivocally make a mistake when it determined that Prestige's failure to submit an Excel-compatible Provider Network File was an immaterial defect; AHCA's decision regarding this ultimate fact was not, in other words, clearly erroneous.

112. The undersigned concludes further that AHCA's discretionary decision to waive the minor irregularity in Prestige's bid was neither arbitrary nor capricious; it was, rather, a reasonable response under the circumstances, one that is justifiable both factually and logically, for reasons discussed above. Care Access's argument that AHCA erred in accepting Prestige's bid notwithstanding its noncompliance with the electronic filing requirements is rejected.

113. Care Access's allegation that Prestige and FTH improperly colluded is based on the anti-collusion provisions of the ITN. Because the relevant portions of the ITN are susceptible to more than one reasonable interpretation, the undersigned concludes that the anti-collusion provisions are ambiguous. See, e.g., Saunders v. Bassett, 923 So. 2d 546, 548 (Fla. 1st DCA 2006) ("Ambiguity exists where more than one literal interpretation is reasonable.").

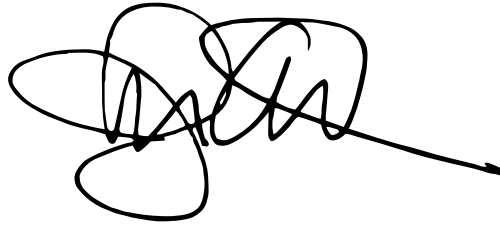
114. AHCA interprets the anti-collusion provisions as applicable only to plans competing within the same region. The undersigned concludes that AHCA's interpretation of its own specifications is within the range of permissible interpretations of the ambiguous language and hence is not clearly erroneous. Therefore, the claim that Prestige improperly colluded with FTH is rejected.

115. Finally, the undersigned found no departure from the ITN specifications in connection with AHCA's decision to set a base price which a bidder could not undercut to its advantage. Therefore, it is concluded that Care Access's objection to the proposed award based upon the common base rate affords no basis for relief.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that AHCA enter a Final Order (a) rescinding the proposed award to Prestige on the ground that Prestige, being minority owned (under 50%) by a group of affiliated health care providers, is not a PSN for the purpose of this procurement; and (b) taking such further remedial action(s)—besides upsetting any other intended awards in any Region—as AHCA, in its discretion as the letting authority, deems necessary or appropriate in light of Prestige's ineligibility to receive the PSN contract in Region 11.

DONE AND ENTERED this 2nd day of January, 2014, in
Tallahassee, Leon County, Florida.



JOHN G. VAN LANINGHAM
Administrative Law Judge
Division of Administrative Hearings
Division of Administrative Hearings
The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-3060
(850) 488-9675 SUNCOM 278-9675
Fax Filing (850) 921-6847
www.doah.state.fl.us

Filed with the Clerk of the
Division of Administrative Hearings
this 2nd day of January, 2014.

ENDNOTES

^{1/} AHCA also received replies from a number of "specialty plans," which are defined by statute as plans serving Medicaid recipients who meet specified criteria based on age, medical condition, or diagnosis. See § 409.962(14), Fla. Stat. Specialty plan awards are not at issue in this proceeding.

^{2/} On October 10, 2013, AHCA published a notice of intent to award additional contracts in Region 11 to Amerigroup and Simply. On October 22, 2013, AHCA published a notice of intent to award an additional contract in Region 11 to Coventry Healthcare of Florida, Inc. ("Coventry"). On October 25, 2013, AHCA published a notice of intent to award an additional contract in Region 11 to Molina. These additional awards were not protested.

^{3/} Coventry and Molina also filed bid protests challenging AHCA's intended awards in Region 11; their petitions were

referred to DOAH on October 17, 2013, together with a number of other petitions challenging proposed awards in Regions 1 through 10. By Order of Consolidation dated October 22, 2013, DOAH Case Nos. 13-4100BID, 13-4101BID, 13-4102BID, 13-4103BID, 13-4104BID, 13-4105BID, 13-4106BID, 13-4107BID, 13-4108BID, 13-4109BID, 13-4110BID, 13-4111BID, 13-4112BID, 13-4113BID, and 13-4114BID were consolidated for all purposes, including final hearing. AHCA subsequently resolved all of the protests except this one, i.e., DOAH Case No. 13-4113BID. Each of the cases that ended with an agreement was dismissed upon notice of the settlement.

^{4/} Section 409.962(6) defines the term "eligible plan" to mean

a health insurer authorized under chapter 624, an exclusive provider organization authorized under chapter 627, a health maintenance organization authorized under chapter 641, or a provider service network authorized under s. 409.912(4)(d) or an accountable care organization authorized under federal law. For purposes of the managed medical assistance program, the term also includes the Children's Medical Services Network authorized under chapter 391 and entities qualified under 42 C.F.R. part 422 as Medicare Advantage Preferred Provider Organizations, Medicare Advantage Provider-sponsored Organizations, Medicare Advantage Health Maintenance Organizations, Medicare Advantage Coordinated Care Plans, and Medicare Advantage Special Needs Plans, and the Program of All-inclusive Care for the Elderly.

^{5/} The ITN similarly defines "Provider Service Network," for purposes of managed medical assistance, as follows:

Provider Service Network (MMA Only) - A network established or organized and operated by a health care provider, or group of affiliated health care providers, that provides a substantial proportion of the health care items and services under a contract directly through the provider or group of affiliated providers. The PSN may

make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians, or other health professionals, or through the institutions. The health care providers must have a controlling interest in the governing body of the provider service network organization.

^{6/} AHCA, perhaps not unreasonably, regards the majority-ownership requirement as the "applicable definition of "controlling interest." AHCA PRO at 33. Whether viewed as the relevant definition of "controlling interest" or a new, stand-alone requirement, the majority-ownership test for PSN status is—as AHCA correctly asserts—among the terms, conditions, and specifications contained in the ITN, which no one timely protested. Id. Thus, the undersigned agrees with AHCA that all objections to the PSN majority-ownership requirement, which is clear and unambiguous, were waived.

^{7/} Specifically, Prestige admits that FTH, with its 40% stake, owns a controlling interest in Prestige. See Prestige PRO at 15. Prestige insists, however, that despite the purchase option it holds, FTH does not own more than 50% of the company.

^{8/} Prestige identified three Other Owners: Florida Premier Health Plan (0.866%); FTH (40%); and Health Foundation of South Florida (1.299%).

^{9/} Not shown in the excerpt are two additional "MMA Provider Type" abbreviations, namely: "FQ = federally qualified health care center"; and "HH = home health care agency."

^{10/} The undersigned takes official recognition of the public record of HRSA explaining the meaning of the term HCCN, which is available online at <http://www.hrsa.gov/healthit/toolbox/HealthITAdoptiontoolbox/OpportunitiesCollaboration/abouthccns.html> (last visited Dec. 29, 2013).

^{11/} According to its 2012 Annual Report, HCNF provided services to 26 member centers. Of these, 13 HCNF members are listed in

Prestige's CMS 1513 as FQHC Owners of Prestige, as are three additional HCNF members under the subcategory of Prestige's Other Provider Owners. In other words, some (but not all) of HCNF's members (or onetime members) hold or held ownership interests in Prestige in their own respective names as separate providers.

^{12/} Actually, calling this designation "debatable" is being generous. As the exhibit's directions made clear, a "provider type" designation in Column 4 of the ownership disclosure table would be appropriate only if the subject owner were a Medicaid provider, which HCNF was not, contrary to Prestige's false representation in this regard. Prestige should have answered "No" to the question asked about HCNF in Column 3 and left Column 4 blank.

^{13/} AHCA PRO at 12.

^{14/} Should resolution of this issue become necessary at some future point in this proceeding, it will be seen that Care Access's position regarding FTH's alleged ownership and control of Prestige is based upon the terms and conditions of the contractual instruments behind the multifaceted transaction under which FTH acquired its 40% stake in Prestige and the option to purchase the remaining 60%. These contracts are in the record and their terms are not in dispute. Thus, the question of Prestige's status as a PSN in light of FTH's ownership, control, and potential acquisition of the company can be decided, if necessary, as a matter of law.

^{15/} Further, the anti-collusion provisions are reasonably understood as prohibitions against secret agreements of an illicit or anti-competitive nature. The focus of such provisions is on putative economic competitors who presumably would have no legitimate business reason to share information regarding their bids or otherwise to cooperate with each other, not on affiliated companies having the sort of business relationship described in section 409.966(3)(b), who would be expected to communicate with each other to some degree about potential bids, if for no other reason than to avoid wasting resources on an intra-regional competition that both could not win.

^{16/} The term "standard of proof" as used in section 120.57(3)(f) reasonably may be interpreted to reference standards of review. This is because, while the "standard of proof" sentence fails to

mention any common standards of proof, it does articulate two accepted standards of review: (1) the "clearly erroneous" standard and (2) the abuse of discretion ("arbitrary, or capricious") standard. (The "contrary to competition" standard—whether it be a standard of proof or standard of review—is unique to bid protests.)

^{17/} An ultimate factual determination is a conclusion derived by reasoning from objective facts; it frequently involves the application of a legal principle or rule to historical facts (e.g., the driver failed to use reasonable care under the circumstances and therefore was negligent); and it may be infused with policy considerations. Reaching an ultimate factual finding requires that judgment calls be made which are unlike those that attend the pure fact-finding functions of weighing evidence and choosing between conflicting but permissible views of reality.

^{18/} From the general principle of deference follows the more specific rule that an agency's interpretation need not be the sole possible interpretation or even the most desirable one; it need only be within the range of permissible interpretations. State Bd. of Optometry v. Fla. Soc. of Ophthalmology, 538 So. 2d 878, 885 (Fla. 1st DCA 1988); see also Suddath Van Lines, Inc. v. Dep't of Env'tl. Prot., 668 So. 2d 209, 212 (Fla. 1st DCA 1996). However, "[t]he deference granted an agency's interpretation is not absolute." Dep't of Nat. Res. v. Wingfield Dev. Co., 581 So. 2d 193, 197 (Fla. 1st DCA 1991). Obviously, an agency cannot implement any conceivable construction of a statute or rule no matter how strained, stilted, or fanciful it might be. Id. Rather, "only a permissible construction" will be upheld by the courts. Fla. Soc. of Ophthalmology, 538 So. 2d at 885. Accordingly, "[w]hen the agency's construction clearly contradicts the unambiguous language of the rule, the construction is clearly erroneous and cannot stand." Woodley v. Dep't of HRS, 505 So. 2d 676, 678 (Fla. 1st DCA 1987); see also Legal Env'tl. Assistance Found. v. Bd. of Cnty. Comm'rs of Brevard Cnty., 642 So. 2d 1081, 1083-84 (Fla. 1994) ("unreasonable interpretation" will not be sustained).

^{19/} If, on the other hand, the agency has followed a clearly erroneous interpretation of an ambiguous specification, then its proposed action ordinarily should not be implemented. Finally, if the agency has sought to proceed in a manner that is contrary to the plain language of a lawful specification, then the

agency's proposed action should probably be corrected, for the preliminary agency action likely would be clearly erroneous or contrary to competition; in that situation, there should be no waiver, because a reasonable person would not protest an unambiguous specification that facially conforms to Florida procurement law.

^{20/} The undersigned was able to comprehend the meaning of the provisions at issue without resort to principles of interpretation or other extrinsic authority. That said, review of the federal statutes and regulations defining the term "provider-sponsored organization"—after which the state's definitions of PSN appear to have been patterned—served to confirm the conclusions about the PSN definition that the undersigned already had reached independently. Cf. 42 U.S.C. § 1395w-25(d); 42 C.F.R. §§ 422.350(b), 422.352, 422.354, & 422.356.

^{21/} In performing this rhetorical sleight of hand, AHCA and Prestige take for granted that, where a group of health care providers are affiliated through their common participation in a non-provider entity, some unexplained alchemic process can work to transform the dross of a non-provider PSN owner into "provider owner" gold. It is as though the provider group—like a strong spice—is able to give the non-provider entity sufficient "provider flavor" to satisfy AHCA's palate, a provider-"seasoned" non-provider being provider enough, evidently, for the purpose of meeting the PSN ownership requirement.

^{22/} It is this type of Medicaid provider to which, in Exhibit C-5, the label "GP" properly would apply.

^{23/} This proposition is logically irrefutable inasmuch as a collection comprising providers and non-providers simply cannot be described, consistent with reason, as a group of providers, any more than an assemblage of human beings and dogs could accurately be described as a group of people: neither group constitutes a homogeneous set of, respectively, providers or people.

^{24/} See Roberts' Fish Farm v. Spencer, 153 So. 2d 718, 720 (Fla. 1963) ("[O]nly duly established courts of law or equity may pierce the corporate existence and look beyond it to the stockholders or to other entities.").

COPIES FURNISHED:

Frank P. Rainer, Esquire
M. Stephen Turner, Esquire
Lacey D. Corona, Esquire
Broad and Cassel
215 South Monroe Street, Suite 400
Tallahassee, Florida 32301

Segundo J. Fernandez, Esquire
M. Christopher Bryant, Esquire
Timothy P. Atkinson, Esquire
Timothy J. Perry, Esquire
Oertel, Fernandez, Bryant
and Atkinson, P.A.
Post Office Box 1110
Tallahassee, Florida 32302-1110

Stuart F. Williams, General Counsel
William M. Blocker, II, Esquire
David W. Nam, Esquire
Agency for Health Care Administration
Fort Knox Building 3, Mail Stop 3
2727 Mahan Drive
Tallahassee, Florida 32308

Joseph M. Goldstein, Esquire
Shutts and Bowen, LLC
Wachovia Center, Suite 2100
200 East Broward Boulevard
Fort Lauderdale, Florida 33301

Martha Harrell Chumbler, Esquire
Kelly Cruz-Brown, Esquire
M. Kip Krieger, Esquire
Carlton Fields, P.A.
215 South Monroe Street, Suite 500
Post Office Drawer 190
Tallahassee, Florida 32302-0190

Robert H. Hosay, Esquire
James A. McKee, Esquire
Foley and Lardner, LLP
106 East College Avenue, Suite 900
Tallahassee, Florida 32301

John A. Tucker, Esquire
Foley and Lardner, LLP
One Independent Drive, Suite 1300
Jacksonville, Florida 32202

Seann M. Frazier, Esquire
Thomas D. Watry, Esquire
Parker Hudson, Rainer
and Dobbs, LLP
215 South Monroe Street, Suite 750
Tallahassee, Florida 32301

Bruce Douglas Lamb, Esquire
Gunster, Yoakley and Stewart, P.A.
401 East Jackson Street, Suite 2500
Tampa, Florida 33602

George Lemieux, Esquire
Gunster, Yoakley and Stewart, P.A.
450 East Las Olas Boulevard, Suite 1400
Fort Lauderdale, Florida 33301

Terry Cole, Esquire
Kellie Scott, Esquire
Gunster, Yoakley and Stewart, P.A.
215 South Monroe Street, Suite 601
Tallahassee, Florida 32301

Michael J. Glazer, Esquire
Stephen C. Emmanuel, Esquire
Erik M. Figlio, Esquire
Ausley McMullen
Post Office Box 391
Tallahassee, Florida 32301

Geoffrey D. Smith, Esquire
Corinne Porcher, Esquire
Timothy B. Elliott, Esquire
Smith and Associates
2834 Remington Green Circle, Suite 201
Tallahassee, Florida 32308

George N. Meros, Jr., Esquire
William E. Williams, Esquire
Amy W. Schrader, Esquire
D. Ty Jackson, Esquire
Andy Bardos, Esquire
GrayRobinson, P.A.
301 South Bronough Street, Suite 600
Post Office Box 11189
Tallahassee, Florida 32302-3189

W. Robert Vezina, III, Esquire
Eduardo S. Lombard, Esquire
Megan S. Reynolds, Esquire
Vezina, Lawrence and Piscitelli, P.A.
413 East Park Avenue
Tallahassee, Florida 32301

Elizabeth Dudek, Secretary
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 1
Tallahassee, Florida 32308

Richard J. Shoop, Agency Clerk
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308

NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 10 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.