STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AHF MCO OF FLORIDA, INC., d/b/a PHC FLORIDA HIV/AIDS SPECIALTY PLAN,

Petitioner,

vs. Case Nos. 18-3507BID
18-3508BID
AGENCY FOR HEALTH CARE ADMINISTRATION, 18-3512BID

Respondent,

and

SIMPLY HEALTHCARE PLANS, INC.,

Intervenor.
_____/

SOUTH FLORIDA COMMUNITY CARE NETWORK, LLC d/b/a COMMUNITY CARE PLAN (SERIOUS MENTAL ILLNESS),

Petitioner,

vs. Case No. 18-3511BID

AGENCY FOR HEALTH CARE ADMINISTRATION,

Respondent.
_____/

SOUTH FLORIDA COMMUNITY CARE NETWORK, LLC, d/b/a COMMUNITY CARE PLAN,

Petitioner,

vs. Case No. 18-3513BID

AGENCY FOR HEALTH CARE ADMINISTRATION,

Respondent.
_____/

SOUTH FLORIDA COMMUNITY CARE NETWORK, LLC d/b/a COMMUNITY CARE PLAN,

Petitioner,

vs. Case No. 18-3514BID

AGENCY FOR HEALTH CARE ADMINISTRATION,

Respondent,

and

SUNSHINE STATE HEALTH PLAN,

Intervenor.
_____/

RECOMMENDED ORDER

Administrative Law Judge John D. C. Newton, II, conducted the final hearing in these consolidated cases in Tallahassee, Florida, August 27 through 29, 2018; September 9 through 12, 2018; September 14, 2018; September 24, 2018; September 26, 2018; and October 1, 2018.

APPEARANCES

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STATEMENT OF THE ISSUES

A. Does Petitioner, AHF MCO of Florida, Inc., d/b/a PHC Florida HIV/AIDS Specialty Plan (Positive), have standing to contest the intended award to Simply for Regions 10 and 11 or to seek rejection of all proposals? (Case No. 18-3507 and 18-3508)

B. Should the intended decision of Respondent, Agency for Health Care Administration (Agency), to contract with Simply Healthcare Plans, Inc. (Simply), for Medicaid managed care plans for HIV/AIDS patients in Regions 10 (Broward County) and Region 11 (Miami-Dade and Collier Counties) be invalidated and all proposals rejected? (Case Nos. 18-3507 and 18-3508)

C. Must the Agency negotiate with Petitioner, South Florida Community Care Network, LLC, d/b/a Community Care Plan (Community), about a plan to provide HIV/AIDS Medicaid managed care services in Region 10 because it was the only responsive proposer of services that was a Provider Service Network (PSN)? (Case No. 18-3512)

D. Must the Agency negotiate with Community to provide Medicaid managed care services in Region 10 for people with Serious Mental Illnesses because Community is a PSN? (Case No. 18-3511)

E. Must the Agency contract with Community to provide Medicaid managed care services for Children with Special Needs in Region 10 because Community is a PSN? (Case No. 18-3513)

F. Must the Agency negotiate with Community to provide Medicaid managed care services for Child Welfare patients in Region 10 because Community is a PSN? (Case No. 18-3514)

PRELIMINARY STATEMENT

INTRODUCTION

This bid protest proceeds under sections 287.057(1)(c) and 120.57(3), Florida Statutes (2018).[1/] It is the culmination of the Agency's year-long procurement process seeking vendors to provide Medicaid managed care plans. Florida has offered Medicaid services since the 1970s. The state and federal governments together fund health care for eligible children, seniors, disabled adults, parents of children, and pregnant women. The program's annual budget exceeds $25 billion and is the largest part of Florida's budget. Part IV of chapter 409, Florida Statutes, establishes the Florida Medicaid program as a statewide, integrated managed care program for all covered services. The Agency administers the Medicaid program. It refers to the managed care program as Statewide Medicaid Managed Care (SMMC). SMMC includes two programs. They are Managed Medical Assistance (MMA) and Long-term Care (LTC). MMA covers the full spectrum of health care. This matter involves a subset of the MMA program called Specialty Plans.

Section 409.966(2) requires the Agency to select eligible Medicaid managed care plans for each of 11 regions of the state defined by section 409.966(2). The law requires the Agency to use the invitation to negotiate (ITN) process created by section

287.057(1)(c). It also requires the Agency to conduct separate and simultaneous procurements.

On July 14, 2017, the Agency simultaneously released 11 ITNs, of 624 pages each. Only the ITN for Region 10 was admitted into evidence. By their conduct and statements, the parties agreed that the content of the other ITNs was identical, save for the region number. During the hearing, the Region 10 ITN (Joint Exhibit 1) served as a proxy for all the ITNs. Consequently, this Recommended Order refers interchangeably to the ITNs in the plural or the singular. The ITN contemplated a period for questions and written answers followed by a response deadline of November 1, 2017. The ITN identified April 16, 2018, as the likely date for posting Notices of Intent to Award. The ITN sought providers of LTC and MMA plans. It also sought providers of "Specialty Plans," a subset of MMA plans. Those are plans eligible to provide MMA services to a defined specialty population pursuant to a contract with the Agency.

Would-be providers filed over 230 responses to the ITNs. The Agency evaluated them, chose to negotiate with some responders, and posted its notices of intent to award contracts on April 24, 2018. Among many others, Positive and Community challenged the Agency's decisions not to contract for their proposed specialty plans.

Positive filed its notice of protest on April 27, 2018, and its Formal Written Protest and Petition for Formal Administrative Hearing on May 4, 2018. It challenged the Agency's award of an HIV/AIDS specialty plan contract to Simply in Regions 10 and 11 and the Agency's decision not to contract with Positive. Positive maintained that the Agency should reject all proposals and re-start the procurement process.

Community filed its notice of protest on April 27, 2018, and its Formal Written Protest and Petition for Formal Administrative Hearing on May 7, 2018. It challenged the Agency's intent to contract with Wellcare of Florida, Inc., d/b/a Staywell Health Plan of Florida Serious Mental Illness Specialty Plan (Staywell), for a Serious Mental Illness Specialty Plan in Region 10, and the Agency's decision not to award Community a contract for a Child Welfare, Children with Special Needs, or HIV/AIDS Specialty Plans in Region 10.

On July 9, 2019, the Agency referred these challenges and 21 other challenges to Agency decisions on proposed specialty plans to the Division of Administrative Hearings (Division). On July 10, 2018, the Agency moved to consolidate all the cases. The Administrative Law Judges to whom the cases had been assigned jointly conducted a hearing on the motion. Afterwards the Judges entered orders consolidating the cases into three different groups with two cases proceeding individually. The

cases were noticed for hearings to be held from August 6 through 8, 2018, with one case set for September 11 through 12, 2018.

On July 31, 2018, the Division, at the request of the parties, conducted an "emergency" scheduling conference in which counsel for all parties participated. The parties presented an agreed proposal to present testimony from all employees of the Agency employees before counsel for all parties and the judges in all the cases. They also represented that they would waive the requirement to conduct the hearings within 30 days of assignment to a judge. The next day the parties filed a Joint Motion, in part, to Consolidate and to Continue Hearings. The motion was granted in all of the cases.

All cases were reassigned to the undersigned. Consolidated Case Nos. 18-3511BID, 18-3516BID through 18-3521BID, 18-3523BID, 18-3528BID, 18-3530BID, 18-3531BID, and 18-3534BID were scheduled to be heard simultaneously August 27 through 29, 2018; September 10 through 12, 14, 24, and 28, 2018; and October 1, 2018. The undersigned convened the hearing as scheduled. The hearing was conducted with all evidence presented during the hearing being considered admitted in every case. Every party had an opportunity to cross-examine every witness, impeach every witness, rebut testimony, rebut exhibits, and impeach exhibits. Since the hearing, the cases have been consolidated under DOAH Case No. 18-3507BID.

THE HEARING

The parties collectively presented the testimony of Jennifer Barrett, Marie Donnelly, Shevaun Harris, Tracey Hurd-Alvarez, Rachel LaCroix, Anne Kaperak, Eunice Medina, Bryan Meyer, Gay Munyon, Devona Pickle, Damon Rich, Abby Riddle, and Erica Floyd Thomas. Joint Exhibits 1-382 were admitted into evidence.

Agency Exhibits 9-16, 18, 20-28, 30-36, 43-60, 75-81, 85-87, 91-117, 124-132, 134-136, 138-141, 143, 147-149, 159-165, 169-172, 174-184, 186-195, 197-211, 218, 219, 226-228, 230-234, 236, 252-258, 266, 269-286, and 298-300 were admitted. The Agency proffered Exhibits 2-4 and 263. They were not admitted.

Positive offered testimony from Deborah Holmes, M.D., and Donna Stidham. Positive Exhibits 1-4, 6, 20-22, 24, 26, 34, 36-38, 42-66, 68-71, 76-78, 80, 85, 86, 88 and 89 were admitted into evidence.

Community offered testimony from Jessica Learner, Miguel Venereo, M.D., and Edward Maszak. Community Exhibits 2 and 14 were accepted in evidence. Community Exhibits 22-26 and 33 were proffered but not admitted.

Simply presented the testimony of Holly Jean Prince and April Bossons. Simply Exhibits 13-19, 21-24, 27-62, and 64-71 were admitted.

Staywell presented the testimony of Elizabeth Miller. It offered only unredacted Joint Exhibit 361, which was admitted.

Sunshine did not offer testimony or exhibits.

The hearing concluded on October 1, 2018. At the hearing's conclusion, the remaining disputes were Consolidated Case No. 18-3507BID, involving HIV/AIDS plans in Regions 10 and 11; Case No. 18-3511BID, involving plans for Serious Mental Illness in Region 10; Case No. 18-3513BID, involving plans for children with special needs in Region 10; and Case No. 18-3514, involving child welfare plans in Region 10.

The Post-hearing Order directed the parties to file proposed recommended orders within ten days of the date of transcript filing. The Order expanded the recommended order page limit to 60 pages. The Order also directed the parties to create and file a single USB flash drive containing only exhibits admitted as evidence and exhibits that were offered, but not admitted, which the parties wished to include in the record for possible appellate review. The parties supplied the requested flash drive.[2/]

The Transcript was filed on October 19, 2018. The parties timely filed proposed recommended orders. They have been considered in the preparation of this Recommended Order.

MOTIONS[3/]

The Agency moved to establish a deadline for Petitioners to amend their protests and petitions. The undersigned denied the motion but directed the parties to each file a Statement of Position. The parties complied. The undersigned deemed the petitions to conform to the statements. The parties are limited to the issues that they specified in the Statements of Position.

At the hearing's onset, the undersigned granted the Agency's Motion for Leave to Supplement Exhibit List and Staywell's Motion to Amend Statement of Position.

Staywell Health Plan of Florida's Request for Judicial Notice (filed August 23, 2018) was granted, in part, and denied, in part. The undersigned took official recognition of Exhibits 1 and 2 to the motion. They were certified copies of documents demonstrating that Staywell Health Plan of Florida is a registered fictitious name used by WellCare of Florida, Inc., and does not constitute the name of a separate affiliated entity. Official recognition of Exhibit 3 to the motion (Arizona Department of Administration records) was denied as moot.

During the hearing, the Agency offered Exhibits 2, 3, 4 and 263. Positive's relevancy objections were sustained. The Agency moved to reconsider. Exhibits 2, 3, and 4 are printouts

from some websites' reports of a protest to the Agency's decision not to contract with Positive.

Exhibit 263 is a memorandum to the ITN procurement file, dated April 26, 2018, from the procurement officer. The memorandum describes emails and letters received by the Office of the Governor and forwarded to the Agency criticizing the Agency decision to not negotiate with Positive. They are attached to the memorandum. An advertisement describing the extent of HIV infections in Florida and praising the HIV services Positive provides is also attached. The advertisement plainly, if indirectly, advocates the Agency contracting with Positive.

The Agency relies on an ITN provision, on page six, to establish relevancy of the exhibits. The provision states:

> Respondents to this solicitation or persons acting on their behalf, may not contact, between the release of this solicitation and the end of the seventy-two (72) hour period following the Agency posting the notice of intended award, excluding Saturdays, Sundays, and State holidays, an employee or officer of the executive or legislative branch concerning any aspect of this solicitation, except in writing to the Procurement Officer or as provided in this solicitation. Violation of this provision may be grounds for rejecting a response.

This provision mirrors section 287.057(23), which requires every solicitation for procurement of commodities or services to

include the statement. The provision is colloquially referred to as the "cone of silence."

The Agency asserts that the communications described in its exhibits 2 through 4 and 263 violate the cone of silence. If it is ordered to reissue the ITN and if Positive submits a proposal, that the Agency says it will not find Positive a responsible vendor or award it a contract because of the alleged cone of silence violation. This, the Agency reasons, divests Positive of standing.

The Agency did not reject Positive's response during the ITN process or otherwise exercise the discretion granted by section 287.057(23). As counsel acknowledged during argument on the objection, the Agency made no finding of a "cone of silence" violation and took no action based on one. In other words, during the ITN evaluation process, the Agency exercised its discretion by not rejecting the response. Now, it has simply changed its mind. This is not a situation where new facts are uncovered or a legal error occurred.

A chapter 120 hearing is a de novo proceeding. Gtech Corp. v. Dep't of the Lottery, 737 So. 2d 615 (Fla. 1st DCA 1999). Rescoring to correct an error is one contemplated outcome. Groves-Watkins Constructors v. State, Dep't of Transp., 511 So. 2d 323 (Fla. 1st DCA 1987). Incorrect scoring and incorrect responsiveness determinations are proper subjects of a bid

dispute proceeding. AT&T Corp. v. State, Dep't of Mgmt. Servs., 201 So. 3d 852 (Fla. 1st DCA 2016). The Agency's decision to now argue that Positive's response must be rejected is not analogous to rescoring the proposal in this proceeding.

This is simply the Agency changing its mind about a discretionary decision. Permitting the agency to raise new reasons for rejecting the proposal is similar to basing a disciplinary action against a licensee on conduct that the administrative complaint proposing discipline did not allege. This violates Florida's Administrative Procedure Act, chapter 120, Florida Statutes. Cottrill v. Dep't of Ins., 685 So. 2d 1371 (Fla. 1st DCA 1996). For these reasons, the motion to reconsider was denied.

ABBREVIATIONS AND ACRONYMS

ABD – Aged, Blind, or Disabled

CAHPS – Consumer Assessment of Healthcare Providers and Systems

CAP – Children and Adolescents' Access to Primary Care Practitioners

CIS – childhood immunization status

HEDIS – Healthcare Effectiveness Data and Information Set

LTC – Long-Term Care

MCO – Managed Care Organization

MMA – Managed Medical Assistance

PSN – Provider Service Network[4/]

SMI - Serious Mental Illness

SMMC – Statewide Medicaid Managed Care

SRC – Submission Requirement Components

TANF – Temporary Aid to Needy Families

FINDINGS OF FACT

THE PARTIES

1. Agency: Section 20.42, Florida Statutes, establishes the Agency as Florida's chief health policy and planning agency. The Agency is the single state agency authorized to select eligible plans to participate in the Medicaid program.

2. Positive: Positive is a Florida not-for-profit corporation operating a Medicaid health plan dedicated to serving people with HIV/AIDS. Positive serves about 2,000 patients in Florida. Positive's health plan is accredited by the Accreditation Association for Ambulatory Healthcare. Its disease management program is accredited by the National Committee for Quality Assurance. Currently, the Agency contracts with Positive for a SMMC HIV/AIDS Specialty Plan serving Regions 10 and 11.

3. Simply: Simply is a Florida for-profit corporation operating a Medicaid health plan dedicated to serving people with HIV/AIDS. Currently, the Agency contracts with Simply to provide a SMMC HIV/AIDS Specialty Plan for Regions 1 through 3

and 5 through 11. Simply has maintained the largest patient enrollment of all HIV/AIDs plans in Florida since Florida started its statewide Medicaid managed care program.

4. Community Care: Community is a Florida limited liability company. It is a PSN as defined in sections 409.912(1)(b) and 409.962(14), Florida Statutes.

5. Staywell: Staywell is the fictitious name for WellCare of Florida, Inc., serving Florida's Medicaid population.

6. Sunshine: Sunshine State Health Plan (Sunshine) is a Florida corporation. It offers managed care plans to Florida Medicaid recipients.

THE INVITATION TO NEGOTIATE

TIMELINE

7. On July 14, 2017, the Agency released 11 ITNs plans for Florida's Medicaid managed care program in 11 statutorily defined regions. Region 10, Broward County, and Region 11, Miami-Dade and Collier Counties, are the regions relevant to this proceeding. Part IV of chapter 409, creates a statewide, integrated managed care program for Medicaid services. This program called Statewide Medicaid Managed Care includes two programs, Managed Medical Assistance and Long-term Care. Section 409.966(2), directs the Agency to conduct separate and simultaneous procurements to select eligible plans for each region using the ITN procurement process created by section

287.057(1)(c). The ITNs released July 14, 2017, fulfilled that command.

8. The Agency issued 11 identical ITNs of 624 pages, one for each region, in omnibus form. They provided elements for four types of plans. Some elements were common to all types. Others were restricted to a specific plan type defined by intended patient population. The plan types are comprehensive plans, long-term care plus plans, managed medical assistance plans, and specialty plans. Section 409.962(16) defines "Specialty Plan" as a "managed care plan that serves Medicaid recipients who meet specified criteria based on age, medical condition, or diagnosis." Responding vendors identified the plan type or types that they were proposing.

9. The Agency issued Addendum No. 1 to the ITNs on September 14, 2017. On October 2, 2017, the Agency issued Addendum No. 2 to the ITNs. Addendum 2 included 628 questions about the ITNs and the Agency's responses to the questions.

10. Florida law permits potential responders to an ITN to challenge the specifications of an ITN, including the addendums. § 120.57(3)(b), Fla. Stat. Nobody challenged the specifications of the ITNs.

11. As contemplated by section 287.057(c)(2), the Agency conducted "a conference or written question and answer period

for purposes of assuring the vendors' full understanding of the solicitation requirements."

12. Positive, Community, and Simply, along with United Healthcare of Florida, Inc., HIV/AIDS Specialty Plan (United), submitted responses to the ITN in Region 10 proposing HIV/AIDS Specialty Plans. Community was the only PSN to propose an HIV/AIDS plan for Region 10.

13. Positive, Simply, and United submitted replies to the ITN for Region 11, proposing HIV/AIDS Specialty Plans.

14. Community, United, Staywell, and one other provider submitted proposals to provide SMI Specialty Plan services in Region 10. Community was the only responding PSN.

15. Community, Sunshine, and Staywell submitted proposals to provide Child Welfare Specialty Plans (CW) in Region 10. Community was the only PSN.

16. Community, Staywell, and two others submitted proposals to offer Specialty Plans for Children with Special Needs (CSN) in Region 10. Community was one of two responding PSNs.

17. Proposal scoring began November 6, 2017, and ended January 16, 2018. The Agency announced its intended awards on April 24, 2018.

18. On April 24, 2018, the Agency issued its notices of intent to award specialty contracts in Regions 10 and 11.

19. The following charts summarize the Agency's ranking of the proposals and its intended awards. The two highest ranked plans, which the Agency selected for negotiations, are identified in bold.

Region 10 – Children with Special Needs

Respondent	Intended Award	Ranking
Staywell	No	**1**
Community	No	**2**
Miami Children's Health Plan, LLC	No	3
Our Children PSN of Florida, LLC	No	4

Region 10 – Child Welfare

Respondent	Intended Award	Ranking
Staywell	No	**1**
Sunshine	**Yes**	**2**
Molina Healthcare of Florida, Inc.	No	3
Community	No	4

Region 10 – HIV/AIDS

Respondent	Intended Award	Ranking
Simply	**Yes**	**1**
United	No	**2**
Community	No	3
Positive	No	4

Region 10 – Serious Mental Illness

Respondent	Intended Award	Ranking
Staywell	**Yes**	**1**
United	No	**2**
Florida MHS, Inc.	No	3
Community	No	4

Region 11 – HIV/AIDS

Respondent	Intended Award	Ranking
Simply	**Yes**	1
United	No	2
Positive	No	3

20. All of the Specialty Plan awards noticed by the Agency went to bidders who also proposed, and received, comprehensive plan awards.

21. The protests, referrals, and proceedings before the Division summarized in the Preliminary Statement followed the Agency's announcement of its intended awards.

TERMS

22. The voluminous ITN consisted of a two-page transmittal letter and three Attachments (A, B, and C), with a total of 34 exhibits to them. They are: Attachment A, Exhibits A-1 through A-8, Attachment B, Exhibits B-1 through B-3, and Attachment C, Exhibits C-1 through C-8. The ITN establishes a two-step process for selecting: an evaluation phase and a negotiation phase. In the evaluation phase, each respondent was required to submit a proposal responding to criteria of the ITN. Proposals were to be evaluated, scored, and ranked. The goal of the evaluation phase was to determine which respondents would move to negotiations, not which would be awarded a contract. The top two ranking Specialty Plans per specialty population would be invited to negotiations. In the negotiation phase, the Agency would negotiate with each invited respondent. After that, the Agency would announce its intended award of a contract to the plan or plans that the Agency determined would provide the best value.

23. Together, the attachments and exhibits combined instructions, criteria, forms, certifications, and data into a "one size fits all" document that described the information

required for four categories of managed care plans to serve Medicaid patients. The ITN also provided data to consider in preparing responses. The transmittal letter emphasized, "Your response must comply fully with the instructions that stipulate what is to be included in the response." The ITNs identified Jennifer Barrett as the procurement officer and sole point of contact with the Agency for vendors.

24. The transmittal letter is reproduced here.

> This solicitation is being issued by the State of Florida, Agency for Health Care Administration, hereinafter referred to as "**AHCA**" or "**Agency**", to select a vendor to provide Statewide Medicaid Managed Care Program services. The solicitation package consists of this transmittal letter and the following attachments and exhibits:
>
> **Attachment A** Instructions and Special Conditions
> **Exhibit A-1** Questions Template
> **Exhibit A-2-a** Qualification of Plan Eligibility
> **Exhibit A-2-b** Provider Service Network Certification of Ownership and Controlling Interest
> **Exhibit A-2-c** Additional Required Certifications and Statements
> **Exhibit A-3-a** Milliman Organizational Conflict of Interest Mitigation Plan
> **Exhibit A-3-b** Milliman Employee Organizational Conflict of Interest Affidavit
> **Exhibit A-4** Submission Requirements and Evaluation Criteria Instructions
> **Exhibit A-4-a** General Submission Requirements and Evaluation Criteria
> **Exhibit A-4-a-1** SRC# 6 - General Performance Measurement Tool
> **Exhibit A-4-a-2** SRC# 9 - Expanded Benefits Tool (Regional)
> **Exhibit A-4-a-3** SRC# 10 - Additional Expanded Benefits Template (Regional)
> **Exhibit A-4-a-4** SRC# 14 - Standard CAHPS Measurement Tool
> **Exhibit A-4-b** MMA Submission Requirements and Evaluation Criteria

Exhibit A-4-b-1 MMA SRC# 6 - Provider Network Agreements/Contracts (Regional)
Exhibit A-4-b-2 MMA SRC# 14 - MMA Performance Measurement Tool
Exhibit A-4-b-3 MMA SRC# 21 - Provider Network Agreements/Contracts Statewide Essential Providers
Exhibit A-4-c LTC Submission Requirements and Evaluation Criteria
Exhibit A-4-c-1 LTC SRC# 4 - Provider Network Agreements/Contracts (Regional)
Exhibit A-4-d Specialty Submission Requirements and Evaluation Criteria
Exhibit A-5 Summary of Respondent Commitments
Exhibit A-6 Summary of Managed Care Savings
Exhibit A-7 Certification of Drug-Free Workplace Program
Exhibit A-8 Standard Contract

Attachment B Scope of Service - Core Provisions
Exhibit B-1 Managed Medical Assistance (MMA) Program
Exhibit B-2 Long-Term Care (LTC) Program
Exhibit B-3 Specialty Plan

Attachment C Cost Proposal Instructions and Rate Methodology Narrative
Exhibit C-1 Capitated Plan Cost Proposal Template
Exhibit C-2 FFS PSN Cost Proposal Template
Exhibit C-3 Preliminary Managed Medical Assistance (MMA) Program Rate Cell Factors
Exhibit C-4 Managed Medical Assistance (MMA) Program Expanded Benefit Adjustment Factors
Exhibit C-5 Managed Medical Assistance (MMA) Program IBNR Adjustment Factors
Exhibit C-6 Managed Medical Assistance (MMA) Program Historical Capitated Plan Provider Contracting Levels During SFY 15/16 Time Period
Exhibit C-7 Statewide Medicaid Managed Care Data Book
Exhibit C-8

Statewide Medicaid Managed Care Data Book Questions and Answers

Your response must comply fully with the instructions that stipulate what is to be included in the response. Respondents submitting

> a response to this solicitation shall identify the solicitation number, date and time of opening on the envelope transmitting their response. This information is used only to put the Agency mailroom on notice that the package received is a response to an Agency solicitation and therefore should not be opened, but delivered directly to the Procurement Officer.

25. The ITN describes the plans as follows:

> Comprehensive Long-term Care Plan (herein referred to as a "Comprehensive Plan") – A Managed Care Plan that is eligible to provide Managed Medical Assistance services and Long-term Care services to eligible recipients.
>
> Long-term Care Plus Plan – A Managed Care Plan that is eligible to provide Managed Medical Assistance services and Long-term Care services to eligible recipients enrolled in the Long-term Care program. This plan type is not eligible to provide services to recipients who are only eligible for MMA services.
>
> Managed Medical Assistance (MMA) Plan – A Managed Care Plan that is eligible to provide Managed Medical Assistance services to eligible recipients. This plan type is not eligible to provide services to recipients who are eligible for Long-term Care services.
>
> Specialty Plan – A Managed Care Plan that is eligible to provide Managed Medical Assistance services to eligible recipients who are defined as a specialty population in the resulting Contract.

26. Specialty Plans are at issue. The ITN did not define, describe, or specify specialty populations to be served. It left that to the responding vendors. Beyond that, the ITN left the ultimate definition of the specialty population for

negotiation, saying in Section II(B)(1)(a) of Attachment B, Exhibit B-3, "[t]he Agency shall identify the specialty population eligible for enrollment in the Specialty Plan based on eligibility criteria based upon negotiations."

27. Some respondents directly identified the specialty population. Simply's transmittal letter stated that it proposed "a Specialty plan for individuals with HIV/AIDS." Positive's response to Exhibit A-4-d Specialty SRC 4, eligibility and enrollment, stated, "the specialty population for the PHC [Positive] plan will be Medicaid eligible, male and female individuals from all age groups who are HIV positive with or without symptoms and those individuals who have progressed in their HIV disease to meet the CDC definition of AIDS." Some others left definition of the specialty population to be inferred from the ITN response.

28. The result is that the ITN left definition of the specialty populations initially to the respondents and ultimately to negotiations between the Agency and successful respondents. Petitioners and Intervenors describe the populations that they propose serving as HIV/AIDS patients, patients with SMI, CSN, and child welfare populations.

29. ITN respondents could have proposed serving only cancer patients, serving only obstetric patients, or serving only patients with hemophilia. The part of the ITN requiring a

respondent to identify the plan type for which it was responding offered only four alternative blocks to check. They were: "Comprehensive Plan," Long-Term Care Plus Plan," "Managed Medical Assistance Plan," or "Specialty Plan."

30. Attachment A to the ITN, labeled "Instructions and Special Conditions," provides an overview of the solicitation process; instructions for response preparation and content; information regarding response submission requirements; information regarding response evaluation, negotiations, and contract awards; and information regarding contract implementation.

31. Exhibits A-1 to A-3 and A-5 to A-7 of the ITN contain various certifications and attestations that respondents had to prepare and verify. Exhibit A-4 contains submission requirement components (SRCs) to which respondents had to prepare written responses. Exhibit A-8 contains the state's standard SMMC contract. ITN Exhibit A-4-a contains 36 general submission requirements and evaluation criteria (General SRCs). ITN Exhibit A-4-b contains 21 MMA submission requirements and evaluation criteria (MMA SRCs). ITN Exhibit A-4-c contains 13 LTC submission requirements and evaluation criteria (LTC SRCs). ITN Exhibit A-4-d contains five specialty submission requirements and evaluation criteria (Specialty SRCs).

32. The responses that the 36 SRCs require vary greatly. Some are as simple as providing documents or listing items. Others require completing tables or spreadsheets with data. Consequently, responses to some SRCS apparently could be reviewed in very little time, even a minute or less. Others requiring narrative responses might take longer. Examples follow.

33. General SRC 1 required a list of the respondent's contracts for managed care services and 12 information items about them including things such as whether they were capitated, a narrative describing the scope of work; the number of enrollees; and accomplishments and achievement.

34. General SRC 2 asked for documentation of experience operating a Medicaid health plan in Florida.

35. General SRC 3 asked for information confirming the location of facilities and employees in Florida.

36. General SRC 12 requested a flowchart and written description of how the respondent would execute its grievance and appeal system. It listed six evaluation criteria.

37. MMA SRC 2 asks for a description of the respondent's organizational commitment to quality improvement "as it relates to pregnancy and birth outcomes." It lists seven evaluation criteria.

38. MMA SRC 10 asks for a description of the respondent's plan for transition of care between service settings. It lists six evaluation criteria including the respondent's process for collaboration with providers.

39. Specialty SRC 1 asks for detailed information about respondent's managed care experience with the specialty population.

40. Specialty SRC 5 asks for detailed information about the respondent's provider network standards and provides five evaluation criteria for evaluating the answers.

41. Exhibit A-8 of the ITN contains the standard SMMC contract.

42. Attachment B and Exhibits B-1 to B-3 of the ITN contain information about the scope of service and core provisions for plans under the SMMC program.

43. Attachment C and Exhibits C-1 to C-8 of the ITN contain information related to the cost proposals and rate methodologies for plans under the SMMC program.

44. The ITN permitted potential respondents to submit written questions about the solicitation to the Agency by August 14, 2017. Some did.

45. On September 14, 2017, the Agency issued Addendum No. 1 to the ITN. Among other things, Addendum No. 1 changed the

anticipated date for the Agency's responses to respondents' written questions from September 15 to October 2, 2017.

46. The Agency issued Addendum No. 2 to the ITN on October 2, 2017. Addendum No. 2 included a chart with 628 written questions from potential respondents and the Agency's answers. Attachment A at A 10-(d) makes it clear that the answers are part of the addendum.

47. Both Addendums to the ITN cautioned that any protest of the terms, conditions, or specifications of the Addendums to the ITN had to be filed with the Agency within 72 hours of their posting. No respondent protested.

48. Instructions for the A-4 Exhibits included these requirements:

> Each SRC contains form fields. Population of the form fields with text will allow the form field to expand and cross pages. There is no character limit. All SRCs, marked as "(Statewide)" must be identical for each region in which the respondent submits a reply. For timeliness of response evaluation, the Agency will evaluate each "(Statewide)" SRC once and transfer the score to each applicable region's evaluation score sheet(s). The SRCs marked as "(Regional)" will be specific and only apply to the region identified in the solicitation and the evaluation score will not be transferred to any other region.

49. The instructions continue:

> Agency evaluators will be instructed to evaluate the responses based on the narrative contained in the SRC form fields and the associated attachment(s), if applicable.
>
> Each response will be independently evaluated and awarded points based on the criteria and points scale using the Standard Evaluation Criteria Scale below unless otherwise identified in each SRC contained within **Exhibit A-4**.

50. This is the scale:

STANDARD EVALUATION CRITERIA SCALE	
Point Score	**Evaluation**
0	The component was not addressed.
1	The component contained significant deficiencies.
2	The component is below average.
3	The component is average.
4	The component is above average.
5	The component is excellent.

51. The ITN further explained that different SRCs would be worth different "weights," based on the subject matter of the SRC and on whether they were General, MMA, LTC, or Specialty SRCs. It assigned weights by establishing different "weight factors" applied as multipliers to the score a respondent received on a criteria. For example, "Respondent Background/Experience" could generate a raw score of 90. Application of a weight factor of three made 270 the maximum possible score for this criteria. "Oversight and Accountability" could generate a raw score of 275. A weight factor of one, however, made the maximum score available 275.

52. General SRC 6 solicits HEDIS data. HEDIS is a tool that consists of 92 measures across six domains of care that make it possible to compare the performance of health plans on an "apples-to-apples" basis.

53. SRC 6 states:

> The respondent shall describe its experience in achieving quality standards with populations similar to the target population described in this solicitation. The respondent shall include, in table format, the target population (TANF, ABD, dual eligible), the respondent's results for the HEDIS measures specified below for each of the last two (2) years (CY 2015/ HEDIS 2016 and CY 2016/ HEDIS 2017) for the respondent's three (3) largest Medicaid Contracts (measured by number of enrollees). If the respondent does not have HEDIS results for at least three (3) Medicaid Contracts, the respondent shall provide commercial HEDIS measures for the respondent's largest Contracts. If the Respondent has Florida Medicaid HEDIS results, it shall include the Florida Medicaid experience as one (1) of three (3) states for the last two (2) years.
>
> The respondent shall provide the data requested in **Exhibit A-4-a-1**, General Performance Measurement Tool[.]
>
> x x x
>
> Score: This section is worth a maximum of 160 raw points
>
> x x x
>
> For each of the measure rates, a total of 10 points is available per state reported (for a total of 360 points available). The respondent will be awarded 2 points if their

> reported plan rate exceeded the national Medicaid mean and 2 points if their reported plan rate exceeded the applicable regional Medicaid mean, for each available year, for each available state. The respondent will be awarded an additional 2 points for each measure rate where the second year's rate is an improvement over the first year's rate, for each available state.
>
> An aggregate score will be calculated and respondents will receive a final score of 0 through 150 corresponding to the number and percentage of points received out of the total available points. For example, if a respondent receives 100% of the available 360 points, the final score will be 150 points (100%). If a respondent receives 324 (90%) of the available 360 points, the final score will be 135 points (90%). If a respondent receives 36 (10%) of the available 360 points, the final score will be 15 points (10%).

54. The SRC is plainly referring to the broad Medicaid-eligible population when it says "the target population (TANF, ABD, dual eligible)." "Dual eligible" populations are persons eligible for Medicaid and Medicare. There, as throughout the ITN, the ITN delineates between a target population of all Medicaid-eligible patients and a specialty population as described in a respondent's ITN proposal.

55. The clear instructions for SRC 6 require, "Use the drop-down box to select the state for which you are reporting and enter the performance measure rates (to the hundredths place, or XX.XX) for that state's Medicaid population for the appropriate calendar year." Community did not comply.

56. General SRC 14 solicits similar data, in similar form using a similar tool, about a respondent's Consumer Assessment of Healthcare Providers and Systems (CAHPS). CAHPS data is basically a satisfaction survey. It asks respondents to provide "in table format the target population (TANF, ABD, dual eligible) and the respondent's results for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) items/composites specified below for the 2017 survey for its adult and child populations for the respondent's three (3) largest Medicaid Contracts (as measured by number of enrollees)."

57. Just like General SRC 6 did with HEDIS data, General SRC 14 ITN instructed bidders to put their CAHPS data for the "target population (TANF, ABD, dual eligible)" "for the respondent's three (3) largest Medicaid Contracts (measured by number of enrollees)" for multiple states into an excel spreadsheet "to the hundredths place[.]" Also, like General SRC 6, General SRC 14 includes an objective formula described in the ITN for scoring bidders' CAHPS data.

RANKING PROVISIONS

58. Attachment A at (D)(4)(c)(2) stated:

> Each response will be individually scored by at least three (3) evaluators, who collectively have experience and knowledge in the program areas and service requirements for which contractual services

> are sought by this solicitation. The Agency reserves the right to have specific sections of the response evaluated by less than three (3) individuals.

59. The ITN's example of how total point scores would be calculated, discussed below, also indicated that some sections may be scored by less than three evaluators. The explanatory chart had a column for "[o]ther Sections evaluated by less than three (3) evaluators. . . ."

60. The Agency's policy, however, has been to assign at least three evaluators to score program specific SRCs.

61. Attachment A at (D)(4)(e)(2) advised respondents how the agency will rank the competing responses. It was clear and specific, even providing an example of the process showing how the scores "will" be calculated. Step one of the explanatory chart stated that the Agency would calculate a total point score for each response.

62. Step two stated that "[t]he total point scores will be used to rank the responses by an evaluator. . . ." Next, the rankings by the evaluator are averaged to determine the average rank for each respondent. This average ranking is critical because ranking is how the ITN said the Agency would select respondents for negotiation and how the Agency did select respondents for negotiation.

63. The step two and step three charts, reproduced below, demonstrate that the ITN contemplated an evaluation process in which each response was to be evaluated in its entirety by three different evaluators, or maybe less than three, but indisputably in its entirety by those who evaluated it. This did not happen.

Step 2

The total point scores will be used to rank the responses by evaluator (Response with the highest number of points = 1, second highest = 2, etc.).

POINTS SUMMARY

Evaluator A		**Evaluator B**		**Evaluator C**		**Evaluator D**	
Respondent	446	Respondent	396	Respondent	311	Respondent	413
Respondent	425	Respondent	390	Respondent	443	Respondent	449
Respondent	397	Respondent	419	Respondent	389	Respondent	435
Respondent	410	Respondent	388	Respondent	459	Respondent	325

RANKING SUMMARY

Evaluator A		**Evaluator B**		**Evaluator C**		**Evaluator D**	
Respondent 1	1	Respondent 1	2	Respondent 1	4	Respondent	3
Respondent 2	2	Respondent 2	3	Respondent 2	2	Respondent	1
Respondent 3	4	Respondent 3	1	Respondent 3	3	Respondent	2
Respondent 4	3	Respondent 4	4	Respondent 4	1	Respondent	4

c) Step 3

An average rank will be calculated for each response for all the evaluators.

Respondent 1	1+2+4+3=10÷4=**2.5**
Respondent 2	2+3+2+1=8÷4=**2.0**
Respondent 3	4+1+3+2=10÷4=**2.5**
Respondent 4	3+4+1+4=12÷4=**3.0**

PROVIDER SERVICE NETWORK PROVISIONS

64. Florida law permits a PSN to limit services provided to a target population "based on age, chronic disease state, or medical condition of the enrollee." This allows a PSN to offer a specialty plan.

65. For each region, the eligible plan requirements of section 409.974(1) state, "At least one plan must be a provider service network if any provider service networks submit a responsive bid." Section 409.974(3) says: "Participation by specialty plans shall be subject to the procurement requirements of this section. The aggregate enrollment of all specialty plans in a region may not exceed 10 percent of the total enrollees of that region." The ITN addressed those requirements.

66. The Negotiation Process section of Attachment A, Instructions and Special Conditions, says:

> **g.** The Agency intends to invite the following number of respondents to negotiation:
>
> **1)** Comprehensive Plans
> · The top four (4) ranking Comprehensive Plans.
>
> **2)** Long-term Care Plus Plans
> · The top two (2) ranking Long-term Care Plus Plans
>
> **3)** Managed Medical Assistance Plans
> · The top two (2) ranking Managed Medical Assistance Plans

4) Specialty Managed Medical Assistance Plans

The top two (2) ranking Specialty Managed Medical Assistance Plans per specialty population.

h. If there are no provider service networks included in the top ranked respondents listed above, the Agency will invite the highest ranked PSN(s) to negotiations in order to fulfill the requirements of Section 409.974(1), Florida Statutes and Section 409.981(1), Florida Statutes.

Emphasis supplied.

67. The ITN specifications in Section D.7, titled Number of Awards, state as follows about Specialty Plan awards:

7. Number of Awards

a. In accordance with Sections 409.966, 409.974, and 409.981, Florida Statutes, the Agency intends to select a limited number of eligible Managed Care Plans to provide services under the SMMC program in Region 10. The Agency anticipates issuing the number of Contract awards for Region 10 as described in **Table 5**, SMMC Region, below, excluding awards to Specialty MMA Plans.

Table 5 SMMC Region	
Region	**Total Anticipated Contract Awards**
Region 10	4

b. If a respondent is awarded a Contract for multiple regions, the Agency will issue one (1) Contract to include all awarded regions.

c. The Agency will award at least one (1) Contract to a PSN provided a PSN submits a responsive reply and negotiates a rate acceptable to the Agency. The Agency, at its sole discretion, shall make this determination.

d. A respondent that is awarded a Contract as a Comprehensive Plan is determined to satisfy the requirements in Section 409.974, Florida Statutes and Section 409.981, Florida Statutes and shall be considered an awardee of an MMA Contract and a LTC Contract. The Agency will issue one (1) Contract to reflect all awarded populations in all awarded regions.

e. In addition to the number of Contracts awarded in this region, additional Contracts may be awarded to Specialty Plans that negotiate terms and conditions determined to be the best value to the State and negotiate a rate acceptable to the Agency. The Agency, at its sole discretion, shall make this determination.

f. The Agency reserves the right to make adjustments to the enrollee eligibility and identification criteria proposed by a Specialty Plan prior to Contract award in order to ensure that the aggregate enrollment of all awarded Specialty Plans in a region will not exceed ten percent (10%) of the total enrollees in that region, in compliance with Section 409.974(3), Florida Statutes.

g. If a respondent is awarded a Contract as a Specialty Plan and another plan type, the Agency will issue one (1) Contract to include all awarded populations in all awarded regions.

68. A prospective vendor asked about the interplay of Specialty Plan options and the PSN requirements. The question and the answer provided in Addendum 2 follow:

> Q. Please clarify the number of PSN awards per region and how PSN awards will be determined based on the PSN's plan type (e.g., Comprehensive, LTC Plus, MMA, Specialty). As you know, Sections 409.974 and 409.981, Florida Statutes require one MMA PSN and one LTC PSN award per region (assuming a PSN is responsive) and the Agency has stated that an award to a Comprehensive Plan PSN will meet the requirements of both statutes. However, can the Agency further clarify whether other types of PSNs would meet the statutory requirements? Specifically, would a PSN LTC Plus award meet the requirements of Section 409.981, Florida Statutes? Similarly, would an award to a Specialty Plan PSN meet the requirements of Section 409.974, Florida Statutes?
>
> A. See Attachment A Instructions and Special Conditions, Section D Response Evaluations, and Contract Award, Sub-Section 7 Number of Awards. Yes, a PSN LTC Plus award would meet the requirements of Section 409.981(2). A Specialty Plan PSN would not meet the requirements of Section 409.974(1).

69. The only reasonable interpretation of this answer is that Specialty Plan PSNs do not satisfy the requirement to contract with a responsive PSN imposed by section 409.974. None of the prospective vendors, including Community, challenged this clarification.

EVALUATION PROCESS

THE EVALUATORS

70. The Agency selected 11 people to evaluate the proposals. The Agency assigned each person a number used to identify who was assigned to which task and to track performance of evaluation tasks. The procurement officer sent the evaluators a brief memo of instructions. It provided dates; described logistics of evaluation; emphasized the importance of independent evaluation; and prohibited communicating about the ITN and the proposals with anyone other than the procurement office. The Agency also conducted an instructional session for evaluators.

71. Evaluator 1, Marie Donnelly: During the procurement, Ms. Donnelly was the Agency's Chief of the Bureau of Medicaid Quality. She held this position for five years before resigning. This bureau bore responsibility for ensuring that the current SMMC plans met their contract requirements for quality and quality improvement measures. Her role specifically included oversight of Specialty Plans.

72. Evaluator 2, Erica Floyd Thomas: Ms. Thomas is the chief of the Bureau of Medicaid Policy. She has worked for the Agency since 2001. Her Medicaid experience includes developing policies for hospitals, community behavioral health, residential treatment, and contract oversight. Before serving as bureau

chief, she served as an Agency administrator from 2014 through 2017. Ms. Thomas oversaw the policy research and development process for all Medicaid medical, behavioral, dental, facility, and clinic coverage policies to ensure they were consistent with the state Plan and federal Medicaid requirements.

73. Evaluator 3, Rachel LaCroix, Ph.D.: Dr. LaCroix is an administrator in the Agency's Performance Evaluation and Research Unit. She has worked for the Agency since 2003. All her positions have been in the Medicaid program. Dr. LaCroix has served in her current position since 2011. She works with the performance measures and surveys that the current SMMC providers report to the Agency. Dr. LaCroix is a nationally recognized expert on healthcare quality metrics like HEDIS. She is also an appointee on the National Association of Medicaid Directors' task force for national performance measures.

74. Evaluator 4, Damon Rich: Mr. Rich has worked for the Agency since April 2009. He is the chief of the Agency's Bureau of Recipient and Provider Assistance. This bureau interacts directly with AHCA's current SMMC care providers about any issues they have, and with Medicaid recipients, usually about their eligibility or plan enrollment. Before Mr. Rich was a bureau chief, he worked as a field office manager for the Agency. Mr. Rich's experience as bureau chief and field office manager includes oversight of the current SMMC Specialty Plans.

75. Evaluator 5. Eunice Medina: Ms. Medina is the chief of the Agency's Bureau of Medicaid Plan Management, which includes a staff of over 60 individuals, who manage the current SMMC contracts. Her experience and duties essentially encompass all aspects of the current SMMC plans. Ms. Medina started working with the Agency in 2014.

76. Evaluator 6, Devona "DD" Pickle: Ms. Pickle most recently joined the Agency in 2011. She also worked for the Agency from November 2008 through November 2010. Ms. Pickle's Agency experience all relates in some way to the Medicaid program. Since March 2013, Ms. Pickle has served as an administrator over managed care policy and contract development in the Bureau of Medicaid Policy. Her job duties include working with the current SMMC contractors. Ms. Pickle is also a Florida licensed mental health counselor.

77. Evaluator 7, Tracy Hurd-Alvarez: Ms. Hurd-Alvarez has worked for the Agency's Medicaid program since 1997. Since 2014, she has been a field office manager, overseeing compliance monitoring for all the current SMMC contractors. Before assuming her current position, Ms. Hurd-Alvarez implemented the LTC SMMC program.

78. Evaluator 8, Gay Munyon: Ms. Munyon is currently the Chief of the Bureau of Medicaid Fiscal Agent Operations. Ms. Munyon began working with the Agency in April 2013. Ms.

Munyon's bureau oversees fulfillment of the Agency's contract with the current SMMC fiscal agent. Her unit's responsibilities include systems maintenance and modifications and overseeing the fiscal agent, which answers phone calls, processes claims, and processes applications. Ms. Munyon has 25 years of experience working with the Medicaid program.

79. Evaluator 9, Laura Noyes: Ms. Noyes started working for the Agency in April 2011. Her years of Agency experience all relate to the Medicaid program, including overseeing six current comprehensive managed care plans by identifying trends in contractual non-compliance.

80. Evaluator 10, Brian Meyer: Mr. Meyer is a CPA, who has worked for the Agency in the Medicaid program since 2011. He is currently chief of the Bureau of Medicaid Data Analytics. Mr. Meyer's primary responsibility is overseeing the capitation rates for the current SMMC contractors. His experience includes Medicaid plan financial statement analysis, surplus requirement calculation analysis and, in general, all types of financial analysis necessary to understand financial performance of the state's Medicaid plans.

81. Evaluator 11, Ann Kaperak: Since April 2015, Ms. Kaperak has served as an administrator in the Agency's Bureau of Medicaid Program Integrity. Ms. Kaperak's unit oversees the fraud and abuse efforts of the current SMMC plans.

She also worked for the Medicaid program from November 2012 through May 2014. Ms. Kaperak worked as a regulatory compliance manager for Anthem/Amerigroup's Florida Medicaid program between May 2014 and April 2015.

82. Positive and Community challenge the Agency's plan selections by questioning the qualifications of the evaluators. The first part of their argument is that the evaluators did not have sufficient knowledge about HIV/AIDS and its treatment. The evidence does not prove the theory. For instance, Positive's argument relies upon criticizing the amount of clinical experience evaluators had managing patients with HIV/AIDS. That approach minimizes the fact that the managed care plan characteristics involve so much more than disease- specific considerations. For instance, many of the components require determining if the respondent provided required documents, verifying conflict of interest documents, management structure, quality control measures, and the like. General SRCs asked for things like dispute resolution models (SRC 16), claims processing information (SRC 17), and fraud and abuse compliance plans (SRC 31). MMA SRCs included criteria, like telemedicine (SRC 4), demonstrated progress obtaining executed provider agreements (SRC 6), and a credentialing process (SRC 12). Specialty SRCs included criteria like copies of contracts for managed care for the proposed specialty population (SRC 1),

specific and detailed criteria defining the proposed specialty population (SRC 4), and the like.

83. The evidence does not prove that disease-specific experience is necessary to evaluate responses to these and other SRCs. SRC 6 involving HEDIS data and SRC 14 involving CAHPS data are two good examples. They required respondents to input data into a spreadsheet. All the evaluators had to do was determine what those numbers showed. Evaluation did not require any understanding of disease or how the measures were created. All the evaluator had to know was the number in the spreadsheet.

84. The second part of the evaluator qualification criticisms is that the evaluators did not give adequate weight to some responses. Positive and Community just disagree with the measures requested and the evaluation of them. They conclude from that disagreement that the evaluators' qualifications were deficient. The argument is not persuasive.

85. The last sentence of paragraph 69 of Positive's proposed recommended order exemplifies the criticisms of Positive and Community of the evaluators' qualifications. It states, "The fact that PHC [Positive] was ranked last among competing HIV plans shows that the SRC evaluators did not understand enough about managing individuals with HIV/AIDs to score its proposal competently." The argument is circular and "ipse dixit". It does not carry the day. The collective

knowledge and experience of the evaluators, with a total of 128 years of Medicaid experience, made them capable of reasonably evaluating the managed care plan proposals, including the Specialty plan proposals. The record certainly does not prove otherwise.

EVALUATION PROCESS

86. The Agency assigned the evaluators to the SRCs that it determined they were qualified to evaluate and score. The Agency did not assign entire responses to an evaluator for review. Instead it elected a piecemeal review process assigning various evaluators to various sections, the SRCs of each response.

87. Paragraph 30 of the Agency's proposed recommended order describes this decision as follows:

> Although the ITN had contemplated ranking each vendor by evaluator, based on an example in the ITN, such ranking presumed a process where all evaluators scored all or nearly all of the responses to the ITN, which had occurred in the procurement five years ago. In this procurement, each evaluator reviewed only a subset of SRCs based on their knowledge, and experience; therefore, ranking by evaluator was not logical because each had a different maximum point score.

88. The initial SRC scoring assignments were:

a. General SRCs 1 through 4, LTC SRCs 1 and 2, and Specialty SRC 1: Marie Donnelly, Laura Noyes, and Brian Meyer.

b. General SRCs 5 through 8, MMA SRCs 1 through 7, LTC SRCs 3 and 4, and Specialty SRCs 1 and 2: Marie Donnelly, Erica Floyd-Thomas, and Rachel LaCroix.

c. General SRCs 9 through 14, MMA SRCs 8 through 11, LTC SRCs 5 through 7, and Specialty SRC 4: Damon Rich, Eunice Medina, and DD Pickle.

d. General SRCs 15 through 17, MMA SRCs 12 and 13, and LTC SRCs 8 through 10: Damon Rich, Tracy Hurd-Alvarez, Gay Munyon.

e. General SRCs 18 through 25, MMA SRCs 14 through 20, LTC SRCs 11 and 12, and Specialty SRC 5: Erica Floyd-Thomas, Eunice Medina, and DD Pickle.

f. General SRCs 26 through 33 and LTC SRC 13: Gay Munyon, Ann Kaperak, and Brian Meyer.

g. General SRCs 34 through 36 and MMA SRC 21: Marie Donnelly, Rachel LaCroix, and Tracy Hurd-Alvarez.

89. The ranking process presented in the ITN and described in paragraphs 62-64, contemplated ranking each respondent by evaluator. The Agency carried this process over from an earlier procurement. In this procurement, despite what the ITN said, the Agency assigned responsibilities so that each evaluator reviewed only a subset of SRCs. Therefore, the ranking of responses by evaluator presented in the ITN could not work. It was not even possible because no one evaluator reviewed a complete response and because each SRC had a different maximum point score.

90. Instead, the Agency, contrary to the terms of the ITN, ranked proposals by averaging the "total point scores" assigned by all of the evaluators.

91. The Agency considered issuing an addendum advising the parties of the change. The addendum would have informed the respondents and provided them an opportunity to challenge the change. The Agency elected not to issue an addendum.

EVALUATION AND SCORING

92. The evaluators began scoring on November 6, 2017, with a completion deadline of December 29, 2017. The 11 evaluators had to score approximately 230 separate responses to the ITNs. The evaluators had to score 67,175 separate items to complete the scoring for all responses for all regions for all types of plans. No one at the Agency evaluated how much time it should take to score a particular item. None of the parties to this proceeding offered persuasive evidence to support a finding that scoring any particular item would or should take a specific length of time or that scoring all of the responses would or should take a specific length of time.

93. Evaluators scored the responses in conference room F at the Agency's headquarters. This secure room was the exclusive location for evaluation and scoring. Each evaluator had a dedicated workspace equipped with all tools and resources necessary for the task. The workspaces included a computer

terminal for each evaluator. The system allowed evaluators to review digital copies of the ITN and proposals and to enter evaluation points in spreadsheets created for the purpose of recording scores. Evaluators also had access to hard copies of the proposals and the ITN.

94. The Agency required evaluators to sign in and to sign out. The sign-in and sign-out sheets record the significant amount of time the evaluators spent evaluating proposals. Evaluators were not permitted to communicate with each other about the responses. To minimize distractions, the Agency prohibited cell phones, tablets and other connected devices in the room. The Agency also authorized and encouraged the evaluators to delegate their usual responsibilities.

95. Agency proctors observed the room and evaluators throughout the scoring process. They were available to answer general and procedural questions and to ensure that the evaluators signed in and signed out. A log sheet documented how much time each evaluator spent in the scoring conference room.

96. Some evaluators took extensive notes. For example, Ms. Median took over 200 pages of notes. Similarly, Ms. Munyon took nearly 400 pages of typewritten notes. The evaluators worked hard. None, other than Dr. LaCroix, testified that they did not have enough time to do their job.

97. The computer system also automatically tracked the evaluators' progress. Tracking reports showed the number of items assigned to each evaluator and the number of scoring items completed. The first status report was generated on December 8, 2017, approximately halfway through the scheduled scoring. At that time, only 28 percent of the scoring items were complete. Ms. Barrett usually ran the status reports in the morning. She made them available to the evaluators to review.

98. The pace of evaluation caused concern about timely completion and prompted discussions of ways to accelerate scoring. Because it was clear that the majority of the evaluators would not complete scoring their SRCs by December 29, 2017, the Agency extended the scoring deadline to January 12, 2018. It also extended the hours for conference room use.

99. Most respondents filed proposals for more than one type of plan and more than one region. This fact combined with the provision in the instructions saying that all statewide SRC responses must be identical for each region and that scores would transfer to each applicable region's score sheets, enabled evaluators to score many SRCs just once. The system would then auto-populate the scores to the same SRC for all proposals by that respondent. This time saving measure permitted scoring on many of the items to be almost instantaneous after review of the first response to an SRC.

100. The fact that so many respondents submitted proposals for so many regions and types of plans provided the Agency another opportunity for time-saving. The Agency loaded Adobe Pro on the evaluators' computers as a timesaving measure. This program allowed the evaluators to compare a bidder's Comprehensive Plan Proposal to the same company's regional and Specialty Plan proposals. If the Adobe Pro comparison feature showed that the proposal response was the same for each plan, the Agency permitted evaluators to score the response once and assign the same score for each item where the respondent provided the same proposal. This speeded scoring. It, however, meant that for SRCs where evaluators did this, that they were not reviewing the SRC response in the specific context of the specialty plan population, each of which had specific and limited characteristics that made them different from the broader General and MMA plan populations. This is significant because so many SRCs required narrative responses where context would matter.

101. There is no Specialty SRCs A-4 instruction requirement for specialty plans analogous to the requirement that responses for statewide SRCs must be identical for each region. In other words, the instructions do not say all SRCs marked as statewide must be identical for each specialty plan proposal and that the Agency will evaluate each Statewide SRC

once and transfer the score to each applicable Specialty Plan score. In fact, according to the procurement officer, the Agency expected that evaluators would separately evaluate and score the statewide SRCs for Comprehensive Plans and for Specialty Plans, even if the same bidder submitted them.

102. Despite the Agency's expectation and the absence of an authorizing provision in the ITN, many evaluators, relying on the Adobe Pro tool, copied the SRC scores they gave to a respondent's comprehensive plan proposal to its specialty plan proposal if the respondent submitted the same response to an SRC for a Comprehensive Plan and a Specialty Plan. For instance, Ms. Thomas (Evaluator 2) and Ms. Munyon (Evaluator 8) did this to save time. Ms. Donnelly (Evaluator 1) did this even when the comprehensive and specialty responses were not identical. This does not amount to the independent evaluation of the responses pledged by the ITN.

103. On separate days, Evaluator 1 scored 1,315 items, 954 items, 779 items and 727 items. On separate days, Evaluator 2 scored 613 items, 606 items, 720 items, 554 items and 738 items. Evaluator 4 scored 874 items on one day. Evaluator 5 scored 813 items in one day. Evaluator 6 scored 1,001 items in one day. Evaluator 8 scored 635 items in one day.

104. The record does not identify the items scored. It also does not permit determining how many of the item scores

resulted from auto-population or assignment of scores based upon previous scoring of an identical response. It bears repeating, however, that the record does not support any finding on how long scoring the response to one SRC or an entire response could reasonably be expected to take.

105. Even with the extended scoring period and time-saving measures, the Agency concluded that Evaluator 3 would not be able to finish all of the SRCs assigned to her. Rather than extend the deadline for scoring a second time, the Agency decided to reassign the nine of Evaluator 3's SRCs that she had not begun scoring to two other evaluators. The Agency did not include scores of other SRCs for which Evaluator 3 had not completed scoring. The Agency only counted Evaluator 3's scores for an SRC if she scored the SRC for everyone. The result was that only two people scored nine of the Specialty Plan SRCs.

106. The Agency did not reassign all of Evaluator 3's SRCs'. It only reassigned the SRCs to evaluators who were qualified to evaluate the items, who were not already assigned those items to score, and who had already finished or substantially completed their own evaluations. The decision to reassign the SRCs was not based on any scoring that had already been completed.

107. The Agency did not allow changes to data submitted by any of the vendors. It allowed vendors to exchange corrupted

electronic files for ones which could be opened and allowed vendors to exchange electronic files to match up with the paper copies that had been submitted.

108. The Agency allowed Community to correct its submission where it lacked a signature on its transmittal letter and allowed Community to exchange an electronic document that would not open. It did not allow Community to change its reported HEDIS scores, which were submitted in the decimal form required by the instructions. Community erred in the numbers that it reported.

109. There is no evidence showing that other vendors received a competitive or unfair advantage over Community in the Agency's review of the SMI Specialty Plan submission for Region 10. There was no evidence that the Agency allowed any other vendors to change any substantive information in their submittals for that proposed specialty in that region.

HEIDIS ISSUES

110. Positive asserts that Simply's proposal is non-responsive because Simply submitted HEDIS data from the general Medicaid population in response to SRC 6 and MMA SRC 14. Positive contends that Simply obtained a competitive advantage by supplying non-HIV/AIDS HEDIS data in response to SRC 6 and MMA SRC 14 because HIV/AIDS patients are generally a sicker group and require more care and because some HEDIS measures

cannot be reported for an HIV/AIDS population. HEDIS stands for Healthcare Effectiveness and Data Information Set and is a set of standardized performance measures widely used in the healthcare industry.

111. The instructions for both SRC 6 and MMA SRC 14 provide, in relevant part:

> The respondent shall describe its experience in achieving quality standards with populations similar to the target population described in this solicitation. The respondent shall include in table format, the target population (TANF, ABD, dual eligible), the respondent's results for the HEDIS measures specified below for each of the last two (2) years (CY 2015/HEDIS 2016 and CY 2016/HEDIS 2017) for the respondent's three (3) largest Medicaid Contracts (measured by number of enrollees). If the respondent does not have HEDIS results for at least three (3) Medicaid Contracts, the respondent shall provide commercial HEDIS measures for the respondent's largest Contracts. If the Respondent has Florida Medicaid HEDIS results, it shall include the Florida Medicaid experience as one (1) of three (3) states for the last two (2) years.
>
> (JE 1 at 75 (SRC 6); JE 1 at 158 (MMA SRC 14)).

112. SRC 6 and MMA SRC 14 instruct respondents to provide HEDIS measures for "the target population (TANF, ABD, dual eligible)." Id.. TANF, ABD, and dual eligible are eligibility classifications for the Medicaid population. The Agency sought information regarding the target Medicaid-eligible population, even from respondents proposing a Specialty Plan, because

Specialty Plans are required to serve all of the healthcare needs of their recipients, not just the needs related to the criteria making those recipients eligible for the Specialty Plan.

113. Following the instructions in SRC 6 and MMA SRC 14, Simply provided HEDIS data from the Medicaid-eligible population for its three largest Medicaid contracts as measured by the total number of enrollees. For the requested Florida HEDIS data, Simply utilized legacy HEDIS data from Amerigroup Florida, Inc., a Comprehensive Plan. Amerigroup and Simply had merged in October of 2017. Therefore, at the time of submission of Simply's proposal, the HEDIS data from Amerigroup Florida was the data from Simply's largest Medicaid contract in Florida for the period requested by the SRCs.

114. Positive asserts that the Agency impermissibly altered scoring criteria after the proposals were submitted when the Agency corrected technical issues within a HEDIS Measurement Tool spreadsheet. SRC 6 and MMA SRC 14 required the submission of numeric data for the requested HEDIS performance measures. To simplify submission of the numeric data for the requested HEDIS performance measures, the Agency required respondents to utilize a HEDIS Measurement Tool spreadsheet.

115. The evaluation criteria for SRC 6 and MMA SRC 14 provided that respondents will be awarded points if the reported

HEDIS measures exceed the national or regional mean for such performance measures. Some respondents, including Positive, entered "N/A," "small denominator," or other text inputs into the HEDIS Measurement Tool.

116. During the evaluation and scoring process, the Agency discovered that if a respondent input any text into the HEDIS Measurement Tool, the tool would assign random amounts of points, even though respondents had not input measureable, numeric data.

117. The Agency reasonably resolved the problem by removing any text and inserting a zero in place of the text.

118. The correction of the error in the HEDIS Measurement Tool prevented random points from being awarded to respondents and did not alter scores in any way contrary to the ITN. It was reasonable and fair to all respondents.

CONCLUSIONS OF LAW

SUMMARY OF ARGUMENTS

119. At the hearing and in its proposed recommended order (PRO), Community acknowledged that any argument based upon improperly scoring its proposals could not result in an award to it. This is because if scores were recalculated to give Community the maximum points available, it would still not have ranked high enough to qualify for negotiation by score.[5/] At this point, Community relies upon two arguments.

It maintains that sections 409.974 and 409.966 and the ITN require the Agency to negotiate with it because it is a PSN. The other is a theory that the Agency's decision not to award any Children with Special Needs plan contracts does not qualify as a rejection of all bids. To the extent that Community is also arguing that Staywell's proposal was not responsive, Community did not prove this claim.

120. Positive maintains that the Agency must reject all proposals to provide a HIV/AIDS plan in Regions 10 and 11 and restart the procurement process. Positive presents one main argument. It maintains that the evaluation of proposals was so flawed that the decision was arbitrary, capricious, and contrary to the specifications of the ITN. The argument rests on four components. They are: (1) the Agency did not use three evaluators for each response, (2) the Agency did not use the ranking method described in the ITN, (3) the evaluators did not have enough time and were not qualified, and (4) evaluators copied scores from scores on general plan proposals to specialty plan proposals. Positive says that the effect of the failings is not quantifiable. This eliminates the ability to test the effect of correcting the errors to determine if the result would place Positive in one of the two rankings entitled to negotiate with the Agency.

JURISDICTION, BURDEN, AND STANDARDS

121. Section 120.57(3), Florida Statutes, governs this proceeding. The Division is to conduct a hearing before an Administrative Law Judge (ALJ) using the procedures applicable to hearings involving disputed issues of material fact created by section 120.57(1), Florida Statutes. § 120.57(3)(d)3, Fla. Stat. Positive and Community bear the burden of proving their claims by a preponderance of the evidence. § 120.57(3)(f), Fla. Stat.; Dep't of Transp. v. J.W.C. Co., 396 So. 2d 778, 787 (Fla. 1st DCA 1981). The statute establishes the standards of proof and review. It states:

> In a competitive-procurement protest, other than a rejection of all bids, proposals, or replies, 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 solicitation specifications. The standard of proof for such proceedings shall be whether the proposed agency action was clearly erroneous, contrary to competition, arbitrary, or capricious. In any bid-protest proceeding contesting an intended agency action to reject all bids, proposals, or replies, the standard of review by an administrative law judge shall be whether the agency's intended action is illegal, arbitrary, dishonest, or fraudulent.
>
> § 120.57(3)(f), Fla. Stat.

122. The ALJ's review is to "evaluate the action taken by the agency." See J.D. v. Fla. Dep't of Child. & Fams., 114 So.

3d 1127, 1132 (Fla. 1st DCA 2013) (discussing abuse of discretion standard of review and the role of a judge in a bid protest proceeding). The hearing is not a de novo proceeding in the traditional sense. See State Contracting & Eng'g Corp. v. Dep't of Transp., 709 So. 2d 607, 609 (Fla. 1st DCA 1998). It is not a forward-looking proceeding intended to formulate agency action. The ALJ may not substitute his judgment for that of the Agency. See Intercont'l Props., Inc. v. State Dep't of HRS, 606 So. 2d 380, 386 (Fla. 3d DCA 1992). Instead, the ALJ engages in a form of review in which he makes findings of fact about actions already taken by the procuring agency. See State Contracting, 709 So. 2d at 609. The ALJ does not re-evaluate the Agency's decision. The ALJ determines whether the Agency followed its governing statutes, its rules, and the ITN specifications.

123. An agency's decision is clearly erroneous when, although there is evidence to support it, after review of the entire record, the tribunal is left with the definite and firm conviction that a mistake has been committed. U.S. v. U.S. Gypsum Co., 333 U.S. 354, 395 (1948). An agency decision is contrary to competition if it unreasonably interferes with the objectives of competitive bidding. See Wester v. Belote, 138 So. 721, 723-24 (1931). Agency action is arbitrary if it is not supported

by facts or logic. See Agrico Chem. Co. v. State Dep't of Envtl. Reg., 365 So. 2d 759, 763 (Fla. 1st DCA 1978). An agency's action is capricious if the agency takes the action without thought or reason, or acts irrationally. Id.

PROVIDER SERVICE NETWORK ISSUE

124. Community has abandoned all claims except the claims based upon the fact that it is a PSN. Community argues that because it is a responsive PSN sections 409.974 and 409.966 require the agency to contract with it in Region 10 for HIV/AIDS, and child welfare. Section 409.974 requires the Agency to select eligible plans through the procurement process described in section 409.966. Section 409.974(1)(j) requires the Agency to procure between two and four plans for Region 10. It says that "[a]t least one plan must be a provider service network if any provider service networks submit a responsive bid." Section 409.974(3) states that "[p]articipation by specialty plans shall be subject to the procurement requirements of this section."

125. Section 409.962 defines a specialty plan as a "managed care plan that serves Medicaid recipients who meet specified criteria based on age, medical condition, or diagnosis." Nothing requires the Agency to contract with them. In fact, the entire Medicaid Managed Care plan scheme grants

the Agency a good deal of discretion in defining and choosing plans through the ITN process.

126. The procurement requirements include section 409.974(2). It establishes quality selection criteria involving agreements, contracts, or other documents showing progress in establishing relationships with medical service providers. It states that these criteria are in addition to the criteria established in section 409.966.

127. Section 409.966 sets forth more procurement requirements. It requires that plans must be capable of providing all covered services. It allows limiting services to a specific target population. A network that limits the services it provides must be able to coordinate and deliver care for all other non-specialty services to the population. The law requires the Agency to select a limited number of plans using the ITN process. It defines the eleven regions of the state for plans. It provides a long list of quality selection criteria. In other words, the procurement requirements invoked by section 409.974(3) are much more than the number of plans per region or a preference for including a PSN if one is available.

128. The statute says only that the Agency must select eligible plans. Section 409.962(7) and (8) defines eligible plan as a number of different providers, including health

maintenance organizations and provider service organizations. They also include a Children's Medical Service Network as authorized under Chapter 391, Florida Statutes, as an eligible plan.

129. The statutes are not clear on the subject of whether the PSN requirement applies to specialty plans. Application of statutory interpretation principles is appropriate. Holly v. Auld, 450 So. 2d 217, 219 (Fla. 1984).

130. The parties begin their statutory interpretation arguments addressing the Agency's interpretation deference doctrine articulated in cases like Bd. of Trs. of the Int. Imp. Tr. Fund v. Levy, 656 So. 2d 1359, 1363 (Fla. 1st DCA 1995). In November 2018, the voters adopted Article V, section 21, Florida Constitution. It provides that a state court or an "officer hearing an administrative action pursuant to general law may not defer to an administrative agency's interpretation of such statute or rule, and must instead interpret such statute or rule de novo." The amendment takes effect January 8, 2018. Art. XI, § 5(e), Fla. Const. In the event of an appeal, this may become germane. In any event, the interpretation of the statutes the Agency argues here is rational. But it is not the interpretation the Agency presented in the ITN.

131. The Agency's interpretation, as argued in this case, is supported by other principles of statutory construction. One is the principle that courts should use common sense when interpreting statutes. Sch. Bd. Of Palm Beach County v. Survivors Charter Schs., Inc., 3 So. 3d 1220, 1235 (Fla. 2009). It supports the conclusion that the Agency's interpretation is reasonable.

132. Application of Community's argument that the PSN requirement applies to Specialty Plans requires, as Community acknowledges, that "the Agency must award a minimum of two specialty plans of the type procured" and that one of them must be a PSN. Community Consolidated PRO at p. 19. Paragraph 23 of Community's Consolidated Proposed Recommended Order also states its position. "None of the language in 409.974 is ambiguous. A plain reading of subsections (1) and (3) require that when the Agency is procuring specialty plans it must acquire a minimum of two in region 10. If a PSN is one of the bidders and is a capable PSN, then one of those two minimum awards must be to the PSN bidder." Community's interpretation greatly increases the number of plans that the Agency may procure.

133. Applied in Region 10, Community's theory could result in the required two plans (MMA), two children with special needs plans, two Serious Mental Illness Plans, two child welfare

specialty plans, and two HIV/AIDS plans for a total of six specialty plans. If vendors had also proposed specialty plans for obstetric patients and orthopedic patients, Community's interpretation would require two each of them as well. This does not make common sense in a regulatory scheme where the Legislature granted the Agency great discretion and demonstrated a preference for limiting the number of plans. Community's interpretation also violates the principle that tribunals should not construe statutes in ways that lead to an absurd result. Murray v. Mariner Health, 994 So. 2d 1051, 1061 (Fla. 2008). Community's interpretation would lead to the absurd result of vendors, simply by proposing a specialty plan, dictating to the state which and how many specialty Medicaid managed care plans will be established.

134. The statutory interpretation advocated by the Agency in its pleadings in this proceeding is more sensible and persuasive.

135. However, in this proceeding the Agency is bound by the terms of the ITN. Section D of the ITN Titled - Negotiation Process, states in subsection 5, g. and h. as follows:

> g. The Agency intends to invite the following number of respondents to negotiation:

1) Comprehensive Plans

The top four (4) ranking Comprehensive Plans.

2) Long-term Care Plus Plans

The top two (2) ranking Long-term Care Plus Plans

3) Managed Medical Assistance Plans

The top two (2) ranking Managed Medical Assistance Plans

4) Specialty Managed Medical Assistance Plans. The top two (2) ranking Specialty Managed Medical Assistance Plans per specialty population.

h. If there are no provider service networks included in the top ranked respondents listed above, the Agency will invite the highest ranked PSN(s) to negotiations in order to fulfill the requirements of Section 409.974(1), Florida Statutes and Section 409.981(1), Florida Statutes.

Emphasis supplied

136. This language is clear and unambiguous. The language "respondents listed above" includes specialty MMA Specialty Plans. The ITN required the Agency to invite the top two Specialty MMA plans and the top-ranked PSN specialty plan respondent to negotiations under section D.S.g. and h. of the ITN Specifications.

137. Community was the only responsive PSN offering HIV/AIDS, child welfare, and Serious Mental Illness Specialty

Plans in Region 10. The Agency did not invite Community to negotiations for the HIV/AIDS, child welfare, and Serious Mental Illness Specialty Plan procurements. The terms of the ITN required it to be invited. This, however, does not mean the Agency is required to contract with Community. The ITN does not say that.

138. The Agency decision to not negotiate with Community is contrary to the solicitation specifications. This makes the decision arbitrary because it is not supported by logic and capricious because it was taken without reason.

THREE EVALUATORS

139. Section 287.057(16)(a)(1) requires the Agency to use at least three qualified individuals to evaluate and score the ITN responses. The statute is clear. It requires the Agency head to appoint "at least three persons to evaluate proposals and replies who collectively have experience and knowledge in the program areas and service requirements for which commodities or contractual services are sought." When the language is clear, the statute should be given its plain meaning. Resort to principles of statutory interpretation is not needed or proper. Daniels v. Fla. Dep't of Health, 898 So. 2d 61, 64-65 (Fla. 2005); Nicoll v. Baker, 989 So. 2d 990-91 (Fla. 1996). Due to the reassignment of some of Evaluator 3's scoring assignments, the evaluation process did not comply

with section 287.057(16)(a)(1). This, Positive argues, is good reason to reject all bids and begin the procurement process anew.

140. Resolution of this issue does not end with the statutory requirement. The ITN was also clear on this subject. It said that the Agency did not intend to have at least three persons evaluate all proposals. Attachment A at (D)(4)(c)(2) said the Agency reserved the "right to have specific sections of the response evaluated by less than three (3) individuals." The example of how total point scores would be calculated disclosed again that the Agency might not use three evaluators for all sections of the responses. The chart showing how the Agency would calculate scores and rank respondents included a column for sections evaluated by less than three evaluators. None of the respondents challenged these provisions. Therefore, all respondents waived the objection to the Agency's use of less than three evaluators. §120.57(3)(b), Fla. Stat.; Consultech of Jacksonville, Inc. v. Dep't of Health, 876 So. 2d 731, 734 (Fla. 1st DCA 2004); Optiplan, Inc. v. Sch. Bd. of Broward Cnty., 710 So. 2d 569, 572 (Fla. 4th DCA 1998) ("[W]ith respect to the constitutional challenge to the RFP's specifications because it awarded points tied to race-based classifications, we agree with the hearing officer that Optiplan waived its right to contest the

School Board's use of the criteria by failing to formally challenge the criteria within 72 hours of the publication of the specifications in a bid solicitation protest.").

141. The Agency's use of less than three evaluators to score some sections of the responses is not grounds for rejecting all proposals.

RANKING

142. The ITN plainly stated that responses would be ranked by evaluator. The record is clear that they were not. The ITN requires a conversion of evaluator scores to an average ranking "by evaluator" pursuant to a three-step process spelled out in the ITN. The ITN's ranking methodology cannot be used here because the Agency divided the scoring assignments among the 11 SRC evaluators such that none of the evaluators scored all SRCs for any of the proposals submitted. Any attempt to convert SRC scores to rankings distorts the weight the ITN accords different SRCs by giving equal weight to each evaluator's scores even though they had materially disparate scoring assignments. Ms. Barrett immediately recognized that the decision to apportion scoring the SRCs and evaluate the responses piecemeal made the ranking process of the ITN impossible and unfair. The Agency chose not to issue an Addendum curing this problem. Instead it determined to proceed

to negotiations based upon total score instead of a "by evaluator" ranking.

143. Simply witness, April Bossons, attempted to show that application of a "by evaluator" ranking would still leave Positive ineligible for negotiation because it would not be ranked first or second. Ultimately, Ms. Bossons acknowledged that she could not rank responses by evaluator, because the evaluators had differing assignments. The record does not show that the rankings would have been the same if the Agency complied with the ITN.

144. The Agency's ranking was contrary to the ITN specifications. The facts and logic do not support it. The Agency rejected at least two logical options. One was to change scoring assignments so that the ITN ranking method would work. Another was to issue an Addendum to the ITN. It did neither. The result is a decision that is arbitrary and capricious. The facts here leave the definite and firm conviction that the Agency committed a consequential mistake when it used a different ranking system than the system described in the ITN. For this reason, the response to the ITNs for Regions 10 and 11 should be rejected and the procurement process renewed.

145. The Agency and Simply rest on the standing principle that a party’s substantial interest must be

determined by the proposed agency action that it challenges. In the bid contest context, this usually means that the protestant must prove that, absent the Agency errors, it would have ranked high enough to receive a contract. Madison Highlands, LLC v. Fla. Hous. Fin. Corp., 220 So. 3d 467 (Fla. 5th DCA 2017). The facts here do not permit application of the change in ranking analysis. The Agency failed to follow the review process of the ITN. If it had, the responses would have been reviewed as a whole, not piecemeal. If it had, different evaluators would have reviewed different responses. The scoring and ranking for every respondent would be affected. The only things certain are that the Agency's evaluation of responses was contrary to the ITN specifications and that the Agency made a mistake fundamentally undermining the review process. Comparison to Hemophilia Health Svcs., Inc. v. Ag for Health Care Admin., Case No. 04-0017BID, (Fla. DOAH Dec. 2, 2005; AHCA Jan. 26, 2006), cited by Simply, is helpful. In that case, the Agency evaluators applied the standards of the request for proposals. Here the Agency intentionally did not use the ranking system of the ITN. The usual issues such as second-guessing evaluators and inconsistent scoring are not dispositive here. The unusual circumstance of the Agency not conforming to its ITN makes it impossible to determine what the outcome would have been, as

Ms. Bossons acknowledged. This is what requires Positive to seek rejection of all bids and gives it standing. See Vertex Standard v. Fla. Dep't Transp., Case No. 07-0488BID (Fla. DOAH Apr. 30, 2007; Fla. Dep't of Transp. May 30, 2007).

OTHER ISSUES

146. Community criticizes the Agency's decision to not contract with any provider of services for children with special needs. This is a decision to reject all responses. The record does not prove that the decision is illegal, arbitrary, dishonest or fraudulent.

147. Positive argues the scoring of HEDIS data is fatally flawed because the Agency substituted zeros for text supplied in fields where the instructions clearly called for numbers. This argument is not persuasive. The Agency's action was rational and fairly applied to all respondents who supplied text instead of the required numbers.

148. Positive argues that the Agency improperly considered the HEDIS data submitted by Simply. The Agency rationally applied the terms of the ITN seeking HEDIS data for the Medicaid target population.

149. Positive also claims that its services are so outstanding that not contracting with it violated Title 42 U.S.C. § 1396a(a)(30)A and 42 U.S.C. § 1396u-2(b)(5)(A). This, too, is unpersuasive and incorrectly interprets the statutes,

which are directed at ensuring that states adequately fund Medicaid.

RECOMMENDATIONS

A. Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Agency for Health Care Administration enter a final order rejecting all responses to the ITNs to provide a Medicaid Managed Care plan for patients with HIV/AIDS in Regions 10 and 11.

B. Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Agency for Health Care Administration enter a final order inviting Community to negotiate to provide Medicaid Managed Care plan in Region 10 for patients with serious mental illness.

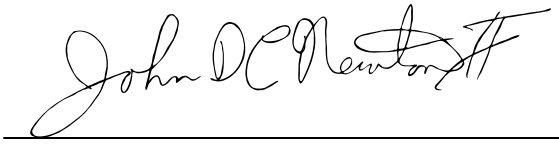
C. Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Agency for Health Care Administration enter a final order inviting Community to negotiate to provide a Medicaid Managed Care plan in Region 10 for patients with serious mental illness.

D. Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Agency for Health Care Administration enter a final order inviting Community to negotiate to provide a Medicaid Managed Care plan in Region 10 for child welfare specialty services.

E. Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Agency for Health Care Administration enter a final order awarding Wellcare of Florida, Inc., d/b/a Staywell Health Plan of Florida, a contract for a specialty Medicaid Managed Care plan for patients with Serious Mental Illness in Region 10.

F. Based on the foregoing Findings of Fact and Conclusions of Law it is RECOMMENDED that the Agency for Health Care Administration enter a final order dismissing the Petition in Case No. 18-3513.

DONE AND ENTERED this _____ day of _____, _____, in Tallahassee, Leon County, Florida.



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Filed with the Clerk of the
Division of Administrative Hearings
this _____ day of _____, ____.

ENDNOTES

[1/] Citations to Florida Statutes are to the 2018 edition unless otherwise noted.

[2/] This flash drive and the many flash drives containing proposed exhibits that the parties provided during the course of the proceeding are retained in the file.

[3/] The parties filed many written motions and made ore tenus motions. This order does not identify all motions. It addresses a few because of their effects on the proceeding.

[4/] "'Provider service network' means an entity qualified pursuant to s. 409.912(1) 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." § 409.962(14), Fla. Stat.

[5/] Community did not raise or preserve the "ranking" issue advanced by Positive.

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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.