FILED
Aug 01, 2023, 9:21 am
OFFICE OF FAIR HEARINGS

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION
OFFICE OF FAIR HEARINGS

[redacted],

PETITIONER, **AHCA Case No.: 23-FH1090**

vs.

AGENCY FOR HEALTH CARE ADMINISTRATION,

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned Hearing Officer convened a telephonic Fair Hearing on the instant case on July 11, 2023, at 9:00 a.m. Eastern Standard Time ("EST").

APPEARANCES

For the Petitioner: [redacted]
Petitioner's Authorized Representative

For the Respondent: Diana Hearod
Medical Health Care Program Analyst
Agency for Health Care Administration

STATEMENT OF ISSUE

The issue is whether Respondent proved by a preponderance of the evidence that Respondent's reduction of Petitioner's request for behavior analysis ("BA") services was correct.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. [redacted] ("[redacted]"), Petitioner's Authorized Representative and [redacted] appeared on behalf of Petitioner.

Lee Ann Williams, Medical Health Care Program Analyst for the Agency and Fair Hearing Liaison for Health Care Administration ("Agency" or "AHCA"), appeared for the Fair Hearing as a representative for Respondent. Dr. Alissa Conway ("Dr. Conway"), Board-Certified Behavior Analyst at the Doctoral Level ("BCBA-D") and Second Level Reviewer for eQHealth Solutions, appeared for the Fair Hearing as a witness for Respondent.

Prior to the Fair Hearing, Petitioner sent to the Office of Fair Hearings and Respondent a ten (10)-page evidence packet, a thirty-two (32)-page evidence packet, and a nine (9)-page evidence packet. The ten (10)-page packet appears in the Office of Fair Hearings' document management system as the file titled "23-FH1090 Evidence.pdf". The thirty-two (32)-page packet appears in the Office of Fair Hearings' document management system as the file titled "23-FH1090 Evidence(2).pdf". The nine (9)-page packet appears in the Office of Fair Hearings' document management system as the file titled "23-FH1090 Evidence(3).pdf". Absent any objections from Respondent, the undersigned admitted the ten (10)-page evidence packet as Petitioner's Composite Exhibit 1 ("PCE 1"), the thirty-two (32)-page evidence packet as Petitioner's Composite Exhibit 1 ("PCE 2"), and the nine (4)-page evidence packet as Petitioner's Composite Exhibit 2 ("PCE 3").

Prior to the Fair Hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one hundred (100)-page evidence packet and a forty-nine (49)-page evidence packet. The one hundred (100)-page packet appears in the Office of Fair Hearings' document management system as the file titled "FH 07.11.2023.pdf". The forty-nine (49)-page packet appears in the Office of Fair Hearings' document management system as the file titled "AHCA Evidence packet 49 pages.pdf". Absent any objections from Petitioner, the undersigned admitted the one

hundred (100)-page evidence packet as Respondent's Composite Exhibit 1 ("RCE 1") and the forty-nine (49)-page evidence packet as Respondent's Composite Exhibit 2 ("RCE 2").

During the hearing, Petitioner stated that [redacted] sent documents to be considered as evidence via e-mail the evening before the hearing, July 10, 2023. The undersigned left the record open until Friday, July 14, 2023, at 5:00 p.m., for the documents Petitioner submitted via e-mail the evening before the hearing, July 10, 2023, to be processed, reviewed, and considered as evidence. However, no such e-mail was received or processed. Petitioner did e-mail AHCA following the conclusion of the hearing, at approximately 10:56 a.m. on July 11, 2023. As the record was held open only for an e-mail sent on July 10, 2023 to be processed, the email sent after the hearing on July 11, 2023 will not be considered as evidence.

FINDINGS OF FACT

1. Petitioner receives Medicaid services on a fee-for-service basis through the Agency. *See* RCE 1 at page 16. eQHealth is a Quality Improvement Organization contracted by the Agency to review prior authorization requests for services. *See* RCE 2 at page 2.

2. Petitioner is [redacted] old. *See* RCE 1 at page 16. Petitioner is diagnosed with [redacted]. *Id* at 16.

3. As provided in the treatment plan, Petitioner is engaging in the following maladaptive behaviors: [redacted]. *Id.* at 54 – 56.

4. On March 30, 2023, Petitioner requested continuation of BA services; specifically, 520 units of code 97155; 208 units of code 97156; and 832 units of code 97153. *See* RCE 1 at 21. In a Notice of Outcome ("NOO"), dated April 12, 2023, Respondent approved 186 units of code

97155; 208 units of code 97156; and 832 units of code 97153. *Id.* at 21 - 22. The NOO states as follows:

> Code: 97155
> Description: Intervention with protocol modification, per 15 minutes
> From: 4/10/23
> Thru: 10/6/23
> Total Units: Denied 334
> Approved 186
>
> Code: 97156
> Description: Family training, per 15 minutes, Lead Analyst
> From: 4/10/23
> Thru: 10/6/23
> Total Units: Approved 208
>
> Code: 97153
> Description: Intervention without protocol modification, per 15 minutes, Lead Analyst, BCaBA or RBT
> From: 4/10/23
> Thru: 10/6/23
> Total Units: Approved 832

The NOO explained the basis for the reduction as follows:

> The request for services is denied in whole or in part because they are not medically necessary as defined in Rule 59G-1.010, Florida Administrative Code. Specially, the requested services are not medically necessary under the following standard(s):
>
> Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs.

The NOO further provided:

> The rationale for our decision is as follows:
>
> > PR Principal Reason – Denial:
> >
> > Submitted information does not support the medical necessity for requested frequency and/or duration.
> >
> > PR Clinical Rationale – Partial Denial

> According to Behavior Analysis Services Coverage Policy requests for services must be based on the medical necessity of the recipient's maladaptive behaviors. The recipient is engaging in problem behaviors that threaten access to typical environments and negatively affects activities of daily living. The provider is using a tiered service delivery model and has not made a compelling justification for services at the intensity requested. The requested hours of ABA services are more than medical necessity.
> . . .

RCE 1 at pages 21 - 22.

5. In a Notice of Reconsideration Determination ("NRD"), dated May 11, 2023, Respondent upheld its decision. *Id*. The NRD explained the basis for the decision as follows:

> PR Recon Determination: At reconsideration all documents were carefully reviewed. The provider did not submit any new documentation that supports the medical necessity of this request. According to The Behavior Analysis Services Coverage Policy (page 6, 9.0.c-d), the recipient of ABA therapy services must engage in maladaptive behavior that interferes with the recipient's daily functioning. Although the recipient is engaging in topographies of maladaptive behaviors, the frequency and intensity of the maladaptive do not support the request for services. This reconsideration has been reviewed, reconsidered and the partial denial is upheld.
> . . .

Page 33 of RCE 1.

6. On May 9, 2023, Petitioner requested a Fair Hearing to challenge the reduction of BA services. On June 16, 2023, the Office of Fair Hearings issued an Order Scheduling Fair Hearing and Prehearing Instructions, setting the hearing for July 11, 2023, at 9:00 a.m. EST.

7. Dr. Conway is a BCBA-D and Second Level Reviewer for eQHealth Solutions. Dr. Conway testified as follows:

a. Petitioner has received services from the provider since [redacted].

b. Dr. Conway cited the definition of medical necessity criteria for the state of Florida, in that for any type of request for behavior analysis services for Medicaid, services must meet all five (5) of the following conditions:

> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
>
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and
>
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
>
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available . . . statewide; and
>
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
> * * *
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

RCE 2 at page 7.

c. The treatment plan is not meeting condition two (2) in that the services requested are in excess of Petitioner's needs.

d. In response to a question from [redacted], Dr. Conway explained the codes as follows:

   i. Code 97153 is any direct service provided by any therapist. It would be BCBA, BCaBA, or RBT.

   ii. Code 97155 is for the BCBA to provide supervision for the BCaBA or RBT, as well as protocol modification to the treatment plan. That is provided in the ratio of typically 10 to 20% of units compared to units received under Code 97153.

e. Petitioner was previously approved for 832 units of code 97153 and these units under this code were approved for the current authorization period as well. Petitioner was previously approved for 208 units of code 97155 or BCBA analyst hours and was approved for 186 units for the current authorization period. Petitioner was previously approved for 104 units of code 97156 or caregiver training and was increased to 208 units for the current authorization period. Dr. Conway opined that the overall total units were not decreased for this authorization but that there was a slight decrease in the Code 97155 hours. According to the BCBA board, the Code 97155 supervision hours are out of ratio of about 10 to 20% of the total direct service hours. The authorization of 186 units is about 1.8 hours per week and that is already above the 20% ratio which would be about 166 units. Dr. Conway explained that Petitioner requested 520 units of Code 97155, which would be way above the 20% request that would typically be authorized.

f. Additional hours requested for the Petitioner should be requested under Code 97153, not Code 97155, because Code 97155 is for supervision protocol modification done by the BCBA.

g. Petitioner is engaging in low levels of problem behaviors and engaging in more independence related to the skill acquisition goals, indicating that there is no need for the additional modifications or higher level [supervision] of Code 97155.

h. Referring to the graph on page 45 regarding the problem behaviors of [redacted], Dr. Conway

explained that [redacted] and [redacted] have had low levels throughout the monthly graph from at least [redacted] through current. For [redacted], Petitioner has shown a decreasing trend of low levels through the last two months of the end of the last authorization period.

i. Referring to the graph at the top of page 46 regarding the same behaviors as paragraph 7(h) displayed on a weekly display, Dr. Conway explained that for the last several weeks of the end of the authorization period, Petitioner shows low to no levels of each of those three maladaptive behaviors: [redacted]

j. Referring to the graph in the middle of page 46, Dr. Conway explained that the graph charts lower level, non-severe problem behaviors of [redacted] and that these behaviors are also at a low level.

k. Referring to the first and second graphs on page 47, Dr. Conway explained that the problem behaviors of [redacted] in both the weekly and monthly graph show a downward trend and low levels throughout the entire authorization period.

l. Referring to the third graph on page 47, Dr. Conway explained that the problem behaviors of [redacted] all show low levels and were just started tracking within the end of the last authorization period.

m. Referring to the graphs on page 49 regarding replacement behaviors, Dr. Conway stated that these graphs are not typically used within the field of behavioral analysis. Dr. Conway explained that the graphs show increases of independence and decreases in the level of prompting.

n. Referring to the top graph on page 50 regarding replacement behaviors, Dr. Conway explained that the two goals of [redacted] show levels responding overtime with a decrease in the prompting and increase in the independence levels.

o. Dr. Conway concluded that Petitioner has maintained low levels of problem behaviors, mostly over the last few months of the authorization period and that this is why the same number of units were approved for the direct care services, to continue to maintain those low levels.

8. [redacted] is Petitioner's [redacted] [redacted] testified to the following:

a. Petitioner is in need of services and the request is not excessive or equal to the amount of hours several professional have suggested that Petition receive.

b. Petitioner is looking for reinstatement of approximately two (2) hours per week of BCBA therapy.

9. [redacted] read portions of the Behavior Support Plan (BSP), dated [redacted]. *See* RCE 1 at pages 44 to 66. The BSP compared current data information from [redacted] to [redacted] with previous BSP updates from [redacted] to [redacted]. *Id.* at 44. According to the BSP, all problem behaviors showed a downward trend for the current period when compared to the previous BSP update. *Id.*

CONCLUSIONS OF LAW

10. The Agency's Office of Fair Hearings has jurisdiction over the subject matter of this proceeding and the parties pursuant to second 409.285(2), Florida Statutes (2019). This order is the final administrative decision of AHCA under section 409.285(2)(a).

11. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R. 59G-1.100(17)(b).

12. Because Respondent reduced a previously approved service, Fla. Admin. Code R. 59G-1.100(17)(b) assigns the burden of proof to the Respondent. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence" (Black's Law Dictionary at 1201, 7th Ed.).

13. The Florida Medicaid Behavior Analysis Services Coverage Policy (October 2017) ("BA Policy"), incorporated by reference in Fla. Admin. Code R. 59G-4.125, governs BA services available under Florida Medicaid. The BA Policy provides as follows:

> **1.0 Introduction**
> Behavior analysis (BA) services are highly structured interventions, strategies, and approaches provided to decrease maladaptive behaviors and increase or reinforce appropriate behaviors.
> . . .
> **1.4.5 Medically Necessary/Medical Necessity**
> As defined in Rule 59G-1.010, F.A.C.
> . . .
> **4.0 Coverage Information**
> **4.1 General Criteria**
> Florida Medicaid covers services that meet all of the following:
> - Are determined medically necessary
> - Do not duplicate another service
> - Meet the criteria as specified in this policy
>
> **4.2 Specific Criteria**

Florida Medicaid covers the following BA services in accordance with the applicable Florida Medicaid fee schedule(s), or as specified in this policy:

4.2.1 Behavior Assessment

One per fiscal year, per recipient, when completed within 30 days of the start of the assessment.

4.2.2 Behavior Analysis

Up to 40 hours per week, per recipient, consisting of services identified on the recipient's behavior plan in order to reduce maladaptive behaviors and to restore the recipient to his or her best possible functional level. Services include:

- Implementing behavior analysis interventions, and monitoring and assessing the recipient's progress towards goals in the behavior plan
- Behavior analysis interventions, for example, discrete trial teaching, task analysis training, differential reinforcement, non-contingent reinforcement, conducting task analyses of complex responses, and teaching using chaining, prompting, fading, shaping, response cost, and extinction
- Training the recipient's family, caregiver(s), and other involved persons on the implementation of the behavior plan and intervention strategies (the recipient must be present when clinically appropriate)

. . .

4.3 Early and Periodic Screening, Diagnosis, and Treatment

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid's General Policies on authorization requirements.

RCE 2 at 40, 42.

14. Appendix 9.0 of the BA Policy provides Review Criteria for Behavior Analysis Services.

These Review Criteria state as follows:

Review Criteria for Behavior Analysis Services

Behavior analysis (BA) services are considered as either the treatment of choice or as an adjunct treatment modality for a variety of conditions and disorders where maladaptive behaviors are part of the recipient's clinical presentation, including behavioral manifestations of diagnoses such as Autism Spectrum Disorder and other behavioral health conditions.

Critical Elements Necessary for ANY Type of Behavior Analysis Service:
The following critical elements **MUST** be satisfied to qualify for BA services:

a. Eligibility – The recipient must meet all criteria for BA services as outlined in the Behavior Analysis Services Coverage Policy, Rule 59G-4.125, F.A.C.
b. Medical necessity – The recipient must meet medical necessity criteria as outlined in Rule 59G-1.010, F.A.C.
c. The recipient currently engages in maladaptive behaviors
d. These maladaptive behaviors interfere with the recipient's daily functioning

1. **Criteria for Initial Behavior Analysis Assessment - BOTH** of the following **MUST** be satisfied:

a. **ALL** critical elements are met
b. Provide submits a valid written physician's order as stipulated in the Behavior Analysis Services Coverage Policy, Rule 59G-4.125, F.A.C.

2. **Criteria for Behavior Analysis Services and Reassessments – ALL** of the following **MUST** be satisfied:

a. **ALL** critical elements are met
b. An assessment or, if applicable, a reassessment, authored by a lead analyst, is provided. An assessment of the maladaptive behavior(s) is a necessary element of the process of identifying the frequency and magnitude of the behaviors as well as the variables associated with the occurrence of the maladaptive behavior(s). This helps in defining what are the functional consequences of the problem behavior(s) so than an adequate behavior plan can be implemented. This (re)assessment **MUST** include, at a minimum, **ALL** of the following:

i. A clear operational description of the maladaptive behavior(s)
. . .

c. A behavior plan authored or updated by a lead analyst. The behavior plan is the cornerstone of the delivery of behavior analysis services and it is based on the information obtained in the assessment. It proposes specific interventions to reduce or eliminate the maladaptive behavior. These interventions take into consideration the variables, both present before the behavior, as well as after the behavior, that influence the occurrence of the maladaptive behavior(s). This plan also includes replacement appropriate behaviors for the recipient to engage in instead of the maladaptive behaviors in order to obtain the same function. The plan must be detailed enough to warrant the requested services and include mechanisms to monitor its effectiveness. This **MUST** include, at a minimum, **ALL** of the following:

i. Observable and measurable descriptions of the maladaptive behavior(s)

ii. Identified function of the maladaptive behavior(s) behavior as a result of the assessment or reassessment conducted
iii. Goals and strategies for changing the maladaptive behavior(s)
iv. Written detailed description of when, where, and how often these goals will be addressed and proposed strategies will be implemented
v. System for monitoring and evaluating the effectiveness of the plan
vi. Safety and crisis plan, if applicable
vii. Summary and recommendations
viii. Discharge criteria
ix. Transition plan (if applicable)

NOTE: Although the assessment and behavior plan were addressed separately in section 2, both of them can be submitted as a single document.

3. Criteria for Continuation of Treatment at the Present Level and/or Using Current Methods: Providers must ensure that ALL of the following criteria are met to request continuation of treatments at the present level or using the current methods. If criteria for 3a is met, but criteria for 3b and/or 3c are not met, then a reduction of the treatment level and/or change of treatment methods may be warranted.

a. ALL criteria listed in 2a, 2b, and 2c regarding critical elements, assessment or reassessment, and behavior plan, are met.
b. The data provided must show evidence that the frequency of the maladaptive behavior(s) has decreased since the last review and, if not, that there is a modification of the behavior plan.
c. The level of functional impairment justifies continuation of BA services. The reviewer utilizes the information provided below as a guide as it relates to the level of functional impairment as expressed through the following behaviors:
i. Safety – aggression, self-injury, property destruction, elopement
ii. Communication – problems with expressive/receptive language, poor understanding or use of non-verbal communications, stereotyped, repetitive language
iii. Self-stimulating, abnormal, inflexible, or intense preoccupations
iv. Self-care – difficulty recognizing risks or danger, grooming, eating, or toileting
v. Other – behaviors not identified above

RCE 2 at 45 – 46.

15. States must provide Early and Periodic Screening, Diagnostic, and Treatment ("EPSDT") services to Medicaid-eligible children under age 21 when requested under the Medicaid state

plan. *See* 42 U.S.C. § 1396a(a)(43); 42 U.S.C. § 1396d(a)(4). According to 42 U.S.C. § 1396d(r)(5), EPSDT services mean, in relevant part, the following items and services:

> Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illness and conditions discovered by the screen services, whether or not such services are covered under the state plan.

RCE 2 at 4 – 5.

16. Petitioner is under age 21, and therefore EPSDT applies to [redacted] request for services. However, a state may place medical necessity limitations on EPSDT services. *See* 42 C.F.R. §§ 440.230(a), (b), (d). Fla. Stat. § 409.905(2) limits EPSDT services with a medical necessity standard:

> The [Agency] shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems and conditions, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

RCE 2 at 13.

17. The Definitions Policy, incorporated by reference in Fla. Admin. Code R. 59G-1.010, defines "Medically Necessary" or "Medical Necessity" as follows:

> The medical or allied care, goods, or services furnished or ordered must meet the following conditions:
>
> - Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate pain
> - Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs
> - Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational

- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider

The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

RCE 2 at 7, 23.

18. The Florida Medicaid Authorization Requirements Policy ("Authorization Requirements Policy") incorporated by reference in Fla. Admin. Code R. 59G-1.053, provides as follows:

3.2.1 Continued Authorization Requests
The QIO shall not deny or reduce the amount, frequency, or duration of a service that is already being provided, unless:

- The reduction is to correct for factual errors or omissions in prior certifications.
- There is a documented improvement in the recipient's medical condition.
- There is a documented change in the recipient's circumstances.
- The reviewing physician determines the recipient will not gain any additional benefit by continuing services at the current level.

RCE 2 at 34.

19. In the NOO, dated April 12, 2023, Respondent reduced Petitioner's BA services – specifically, the elimination of 334 units of Code 97155. *See* ¶ 4. Respondent explained that continuing services at the prior level was not medically necessary, specially that 334 units of Code 97155 were not "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment" and were "in excess of the patient's needs." *Id.* Respondent further stated that because Petitioner is engaging in low levels of problem behaviors and engaging in more independence related to the skill acquisition goals, that there is no medical necessity for the additional modifications or higher level of services of Code 97155. *See* ¶ 7(g).

20. As Respondent bears the burden of proof, Respondent must show that continuing BA services at the prior level is no longer medically necessary for Petitioner. A component of medical necessity is that such services must be "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment and not in excess of the patient's needs." The code at issue, 97155, is for the BCBA to provide supervision for the BCABA or RBT, as well as protocol modification to the treatment plan. *See* ¶ 7(d)(ii). Code 97155 is a higher level of supervision. *See* ¶ 7(g). As shown by the record, Petitioner is engaging in maladaptive behaviors but at low levels. *Id.* Dr. Conway concluded that based on Petitioner's low levels of problem behaviors, the same number of units of BCBA services were approved. *See* ¶ 7(o). Therefore, based on the testimony of Dr. Conway and the information provided, Respondent demonstrated that the requested BA services are in excess of Petitioner's needs.

21. As QIO for the Agency, eQHealth is authorized to reduce services when the reviewing physician determines the recipient will not gain any additional benefit by continuing services at the current level. *See* ¶ 18. As testified to by Dr. Conway and as shown in the BSP, Petitioner's problem behaviors are at low levels and are trending downward. *See* ¶ 7(k) and 9. Therefore, based on the credible testimony of Dr. Conway and the record evidence, the undersigned concludes that would not gain any additional benefit by continuing services at the current level.

22. Upon consideration of the testimony provided, evidence submitted, and applicable policies, the undersigned concludes that Respondent did prove by a preponderance of the evidence that the reduction of BA services was medically necessary. Looking at all the evidence relevant to the particular needs of Petitioner, Respondent has demonstrated that the previously authorized services, based on the treatment plan at issue in this case, are not necessary to correct

or ameliorate a defect or a physical and mental illness or condition. Accordingly, Respondent proved by a preponderance of evidence that Respondent's reduction of BA services was correct.

IT IS HEREBY ORDERED AND ADJUDGED THAT:

Respondent's reduction of BA services is **AFFIRMED**. Petitioner's appeal based on Respondent's termination is **DENIED**.

DONE AND ORDERED this 1st day of August, 2023 in Tallahassee, Leon County, Florida.

KAMEISHA PRESLEY, Hearing Officer
Agency for Health Care Administration
Office of Fair Hearings
2727 Mahan Drive, Mail Stop # 11
Tallahassee, FL 32308-5407

NOTICE OF A RIGHT TO JUDICIAL REVIEW

A PARTY WHO IS ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO JUDICIAL REVIEW, WHICH SHALL BE INSTITUTED BY FILING THE ORIGINAL NOTICE OF APPEAL WITH THE AGENCY CLERK OF AHCA, AND A COPY, ALONG WITH THE FILING FEE PRESCRIBED BY LAW, WITH THE DISTRICT COURT OF APPEAL IN THE APPELLATE DISTRICT WHERE THE AGENCY MAINTAINS ITS HEADQUARTERS OR WHERE A PARTY RESIDES. REVIEW PROCEEDINGS SHALL BE CONDUCTED IN ACCORDANCE WITH THE FLORIDA APPELLATE RULES. THE NOTICE OF APPEAL MUST BE FILED WITHIN 30 DAYS OF THE RENDITION OF THE ORDER TO BE REVIEWED.

COPIES FURNISHED TO:

[redacted]

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