

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



FILED

Oct 02, 2023, 9:56 am
OFFICE OF FAIR HEARINGS

[REDACTED],

PETITIONER,

AHCA Case No.: 23-FH1498

vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the Office of Fair Hearings convened a telephonic Fair Hearing on the instant case on August 29, 2023, at 10:03 a.m. Eastern Standard Time (“EST”).

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner’s Authorized Representative

For the Respondent:

Marielisa Amador
Medical Health Care Program Analyst
Agency for Health Care Administration

STATEMENT OF ISSUE

The issue is whether Petitioner proved by a preponderance of the evidence that Respondent’s decision to deny Behavior Analysis services was incorrect.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. [REDACTED] (“[REDACTED]”),
Petitioner’s Authorized Representative and [REDACTED] appeared on behalf of Petitioner.

Marielisa Amador, Medical Health Care Program Analyst for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared on behalf of Respondent. Dr. Elizabeth Conway (“Dr. Conway”), BCBA at the doctoral level and Second Level Reviewer for eQHealth Solutions Inc. (“eQHealth”) appeared as a witness for Respondent.

Interpreter Raphael, with Language Line Solutions, provided Spanish translation services for Petitioner.

Petitioner did not introduce any exhibits at the Fair Hearing.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a three hundred and five (305)-page evidence packet. The evidence packet appears in the Office of Fair Hearings’ document management system as “[REDACTED] FH 08.29.2023 1-85.pdf,” “[REDACTED] FH 08.29.2023 86-125.pdf,” “[REDACTED] FH 08.29.2023 126-167.pdf,” “[REDACTED] FH 08.29.2023 168-203.pdf,” “[REDACTED] FH 08.29.2023 204-247.pdf,” “[REDACTED] FH 08.29.2023 248-286.pdf,” and “[REDACTED] FH 08.29.2023 286-305.pdf.” Absent an objection from Petitioner, the undersigned admitted the evidence packet into evidence as Respondent’s Composite Exhibit 1.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a forty-nine (49)-page evidence packet. The evidence packet appears in the Office of Fair Hearings document management system as the file title “23-FH1498 AHCA evidence (Pages 1 – 49 of 49).pdf.” Absent an objection from the Petitioner, the undersigned admitted the evidence packet into evidence as Respondent’s Composite Exhibit 2.

FINDINGS OF FACT

1. Petitioner receives Medicaid services on a fee-for-service basis from the Agency. eQHealth is a Quality Improvement Organization contracted by the Agency to review prior authorization requests for services. See Respondent's Composite Exhibit 2 at page 2.

2. Petitioner is [REDACTED] ([REDACTED]-[REDACTED]) old. See Respondent's Composite Exhibit 1 at page 21. Petitioner is diagnosed with [REDACTED]. *Id.*

3. Petitioner's provider, [REDACTED] submitted a Behavior Analysis Assessment ("Treatment Plan"). According to the Treatment Plan, Petitioner is engaging in the following maladaptive behaviors: [REDACTED]
[REDACTED]
[REDACTED]. *Id.* at 140.

4. Petitioner requested BA services. In a Notice of Outcome ("NOO"), dated June 14, 2023, Respondent denied Petitioner's request. *Id.* at 28-29. The NOO explained the basis for the determination as follows:

[T]he requested services are not medically necessary under the following standard(s):

Consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.
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:

Submitted information does not support the medical necessity for the requested frequency and/or duration.

PR Clinical Rationale – Denial: According to the Florida Medicaid State Plan (Appendix 9.2.b), all treatment plans submitted for modification of care must include updated data for all behaviors under treatment as well as changes to the treatment plan, if necessary. The provider was requested to submit baseline graphs for all behaviors under treatment. The baseline data must be graphed data

for behaviors directly observed by the analyst during the assessment for maladaptive, replacement/skill acquisition, and caregiver goals. The provider has not submitted all the graphs (graphs show weekly averages). The request for services is denied.

Id.

5. Petitioner requested reconsideration of the Respondent's decision. In a Notice of Reconsideration Determination ("NRD"), dated June 23, 2023, Respondent upheld its decision.

Id. at 40-41. The NRD explained the basis for the decision as follows:

The reason for the denial is that the services are not medically necessary as defined in 59G-1.010, Florida Administrative Code. Specifically the 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.
Consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.

PR Recon Determination: At reconsideration all documents were carefully reviewed. The supporting documentation does not meet generally accepted practiced within the field of applied behavior analysis and standards set forth in the Florida Behavior Analysis Services Coverage Policy (Pages 6-7). The provider was approved to complete an assessment. The provider has not submitted all observed graphed data for skill acquisition goals and maladaptive behaviors that were to be completed during the assessment. The provider was requested to produce those graphed data to initiate behavior analysis services. The provider has submitted graphed data that do not reflect information in the treatment plan. The data to support this request appears fabricated. This denial is upheld.

Id.

6. On June 19, 2023, Petitioner requested a Fair Hearing to challenge the denial of BA services. On August 4, 2023, the undersigned issued an Order Scheduling Fair Hearing and Prehearing Instructions, setting the hearing for August 29, 2023, at 9:00 a.m. EST.

7. [REDACTED] testified that Petitioner received thirty (30) hours per week of BA services for [REDACTED] before the services were terminated. [REDACTED] asserted that Petitioner has regressed since

the services were terminated. Further, [REDACTED] argued that Petitioner's [REDACTED] and [REDACTED] support Petitioner receiving BA services.

8. Dr. Conway testified as follows:

- a. Petitioner previously received thirty (30) hours per week of BA services with the different provider for approximately [REDACTED] before the services were terminated.
- b. Standards of care in the field of BA require the provider to provide a behavior assessment authored by a lead analyst. The assessment contains baseline data gathered by the provider, identifies maladaptive behaviors, and provides baseline data prior to the start of treatment. The assessment helps define the functional consequences of the problem behaviors so that an adequate behavior plan can be implemented.
- c. In this case, Respondent approved code 97151 - an initial BA assessment to be completed by the provider's lead analyst. However, the Treatment Plan does not meet standards of care in the field of BA. According to council of [REDACTED] the practice of direct observation of data as part of an assessment is necessary to begin ABA services. The functional assessment allows the identification of maladaptive behaviors and their functions. The analyst can then understand the behaviors and surrounding variables that cause an increase or decrease in the behaviors. The Treatment Plan indicates that the lead analyst completed a direct observation of Petitioner, but the data presented in the assessment does not align with the information presented in the Treatment Plan.

- d. For example, the Maladaptive Behaviors Information section of the Treatment Plan, contains a table for [REDACTED] *Id.* at 68. The Baseline Weekly average at the far right top of the table displays baseline at a weekly average of [REDACTED]. This “average” is extrapolated from indirect reports and not from the direct observations of a behavior analyst. The provider was asked to address this concern and did not submit the appropriate graphs. *Id.* at 45. This is inconsistent with the BA Policy criteria 2b, which requires that baseline data must be collected before to understand level of maladaptive behavior before treatment begins.
- e. The Treatment Plan data graph for maladaptive behaviors appears to be fabricated. Each data graph records 3 days of assessment with 2 hours for each assessment period. *Id.* at 81. The first data point for [REDACTED] shows an average of [REDACTED] incidents of [REDACTED] for each 2-hour observation period. This would indicate a rate of approximately [REDACTED] [REDACTED] per hour during each of the 3 observation periods on the graph. This pattern continues across all of the other maladaptive behavior data graphs. *Id.* at 81-84. For example, the graph for [REDACTED] [REDACTED] interaction reports over [REDACTED] instances for each 2-hour observation period and would suggest that the Petitioner was not present during the entire observation. The graphs for [REDACTED] [REDACTED] graphs, again, depict high frequency behavior during each 2-hour observation period.
- f. The Treatment Plan data graphs for replacement behaviors show that Petitioner’s replacement skills are all at [REDACTED] percent. *Id.* at 99 – 104. This would indicate [REDACTED]

percent independence or [REDACTED] accuracy across all acquisition skills. This information is not credible.

- g. In summary, standards of care in BA reinforce the need for the lead analyst to accurately assess and graph behaviors by direct observation in order to determine the functions of behavior and relevant treatment. The assessment is crucial in building the foundation for any service in the field of ABA. The data in the Treatment Plan at issue are not from direct observation by the lead analyst and do not reflect the information submitted in the assessment.

CONCLUSIONS OF LAW

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

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

11. Because Petitioner requested a new service, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to Petitioner. 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.)

12. 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 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 sectioned 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.

...

Pages 1 – 3 of BA Policy.

13. 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 that 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

...

5. Criteria for Discharge from Behavior Analysis Services - ONE or MORE of the following **MUST**

be satisfied:

- a. The critical elements are **no longer met**.
- b. The data provided shows that the frequency and severity of maladaptive behavior(s) has declined to the point that they no longer pose a barrier to the child's ability to function in his/her environment.
- c. The data provided shows the recipient has made no progress toward any goals in the last 12 consecutive months.
- d. The level of functional impairment as expressed through behaviors no longer justifies continued BA services.
- e. Parent/guardian withdraws consent for treatment.

Pages 6 – 8 of BA Policy.

14. 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.

15. Petitioner is under age 21, and therefore EPSDT applies to the request for services.

However, a state may place medical necessity limitations on EPSDT services. *See* 42 C.F.R. §§

440.230(a), (b), (d). Section 409.905(2), Florida Statutes, 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.

16. The Florida Medicaid Definitions Policy (“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.

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

3.0 Determination Process

3.1 Review Criteria

The QIO may use a national standardized set of criteria, or other set of criteria, approved by AHCA, as a guide for authorizations performed at the first review level. If services cannot be approved at the first level review, the QIO's physician peer reviewer will determine medical necessity using his or her clinical judgment, acceptable standards of care, state and federal laws, and AHCA's medical necessity definition.

3.2 Review Process

The QIO will review each authorization request and will approve, deny, or request additional information. The QIO may deny a portion of the requested units of service if it cannot substantiate medical necessity based upon the information submitted.

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 error 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.

Page 3 of Authorization Policy.

18. In the instant case, Respondent denied Petitioner's request for BA services. *See supra* ¶ 4, 5. In the NOO Respondent explained that the services at issue do not meet medical necessity criteria. Specifically, the additional services did not meet the requirement that services must be "[i]ndividualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs" and "[c]onsistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational" based on the submitted information. *See supra* ¶ 4, 5.

19. As provided by the BA Policy and EPSDT requirements, the recipient must meet the medical necessity criteria as outlined in Fla. Admin. Code R. 59G-1.010. *See supra* ¶ 13-15. As

stated in section 2.83 of the Definitions Policy, all five components of medical necessity must be met. Two components of medical necessity are that services must be “[i]ndividualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient’s needs” and “[c]onsistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.” See supra ¶ 16. The behavior plan is the cornerstone of the delivery of behavior analysis services, and it is based on the information obtained in the assessment. See supra ¶ 13. The Authorization Requirements Policy states that eQHealth may deny a portion of the requested units of service if it cannot substantiate medical necessity based upon the information submitted. See supra ¶ 17.


20. At the Fair Hearing, ██████████ testified that the BA services at issue are necessary to prevent regression and are supported by Petitioner’s ██████████ and ██████████. See supra ¶ 6. However, 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. See supra ¶ 16. In this case, Dr. Conway provided credible and persuasive testimony that the requested services are inconsistent with standards of care in the field of behavior analysis and lacks credibility. Standards of care in the field of BA require the provider to provide a behavior assessment authored by a lead analyst. See supra ¶ 8, 13. The assessment contains baseline data gathered by the provider, identifies maladaptive behaviors, and provides baseline data prior to the start of treatment. See supra ¶ 8, 13. The assessment helps define the functional consequences of the problem behaviors so that an adequate behavior plan can be implemented. See supra ¶ 8, 13. In this case, the data presented in the behavior assessment does not align with the information presented in the Treatment Plan.

22. Upon consideration of the testimony provided, evidence submitted, and applicable polices, Petitioner did not prove by a preponderance of the evidence that the BA services at issue meet medical necessity criteria. Looking at all the evidence relevant to the particular needs of Petitioner, Petitioner has not demonstrated that the BA services, based on the Treatment Plan at issue in this case, are necessary to correct or ameliorate a defect or a physical and mental illness or condition. Accordingly, Petitioner did not prove by a preponderance of the evidence that Respondent's denial of BA services was incorrect.

IT IS HEREBY ORDERED AND ADJUDGED THAT:

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

DONE and **ORDERED** this 2nd day of October 2023, in Tallahassee, Leon County, Florida.

Laura Gallagher
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LAURA GALLAGHER, 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:



**AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com**