



RICK SCOTT  
GOVERNOR

*Better Health Care for all Floridians*

ELIZABETH DUDEK  
SECRETARY

December 21, 2011

To: All Health Plans

This communication provides health plans guidance and form changes associated with the Subscriber Assistance Program effective January 1, 2012.

### Background

Section 2719 of the Public Health Service Act includes very specific standards for group health plans and health insurance issuers regarding external review of adverse benefit determinations. An adverse benefit determination is defined as, “a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based on the information provided, does not meet the health carrier’s requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness and the requested service or payment for the service is therefore denied, reduced or terminated”. Adverse benefit determination also includes rescissions of coverage. These standards apply to all health plans with the exception of Medicaid, Medicare, Healthy Kids, Prepaid Health Clinics, and those plans that are considered “grandfathered” under 45 CFR, Section 147.140. The Department of Health and Human Services (DHHS) Center for Consumer Information and Insurance Oversight has informed the Office of Insurance Regulation that the Florida Subscriber Assistance Program process does not meet the required components of the federal law. As a result, all final internal adverse benefit determinations issued to enrollees in health plans (with the exception of those described above) on or after January 1, 2012, are subject to the federally-mandated external review process.

### Subscriber Assistance Program (SAP) Changes Effective January 1, 2012

As of January 1, the SAP will:

- Continue to handle grievances for issues not covered under the federal law.
- Continue to handle unresolved grievances from Medicaid Managed Care Plans as well as Florida Healthy Kids, Prepaid Health plans, and Prepaid Health Clinics. These types of plans are not included in the federal process.
- Continue to handle all unresolved grievances for “grandfathered” plans. It is the responsibility of the health plan to determine “grandfathered” status of plans.
- Only accept a grievance that is subject to federal external review requirements *after* the federal process has been completed.



Subscriber Assistance Program (SAP Changes Effective January 1, 2012)

- Beginning with the first quarter reports for 2012 (January – March 2012), health plans are directed to submit two Quarterly Reports of Subscriber Grievances, one for subscribers in grandfathered plans and one for those in non-grandfathered plans. AHCA Form 3160-0006 has been modified and is now recommended AHCA Form 3160A, Grandfathered Plans and recommended AHCA Form 3160B, Non-Grandfathered Plans. Copies of these revised reporting forms are included with this communication and are available at <http://ahca.myflorida.com/MCHQ/Consumer/SPSAP/forms.shtml>.
- For subscriber grievances submitted to the Subscriber Assistance Program after January 1, 2012, plans must respond on recommended AHCA Form 3160-0008, which now includes a case category “Commercial-Not Subject to Federal External Review” as a choice for case category. A copy of the revised format is included for information purposes.

Please ensure that your plan subscriber notices are modified to provide appropriate avenues of appeal effective January 1, 2012. DHHS Technical Release 2011-12 dated June 22, 2011, includes sample notices for federal external review cases. This release is available at [http://cciio.cms.gov/resources/files/appeals\\_srg\\_06222011.pdf](http://cciio.cms.gov/resources/files/appeals_srg_06222011.pdf). Current notices listing the SAP process should continue to be used for those actions not subject to federal external review requirements.

If you have questions, please contact Carol Greenwood at (850) 412-4319 or [Carol.Greenwood@ahca.myflorida.com](mailto:Carol.Greenwood@ahca.myflorida.com).



Sue Conte  
Bureau Chief  
Managed Health Care

Attached:

Recommended AHCA Form 3160A  
Recommended AHCA Form 3160B  
Recommended AHCA Form 3160-0008

AGENCY FOR HEALTH CARE ADMINISTRATION

Subscriber Assistance Program

**Quarterly Report Of Subscriber Grievances  
Grandfathered Plans**

Managed Care Entity: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Reporting Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Reporting Period: **Year:** \_\_\_\_\_

- \_\_\_\_ January 1 to March 31
- \_\_\_\_ April 1 to June 30
- \_\_\_\_ July 1 to September 30
- \_\_\_\_ October 1 to December 31

Report should be submitted  
on a *calendar* quarter not  
a fiscal quarter.

A - Total number of formal subscriber grievances ***not resolved*** to the full satisfaction of the subscriber ***after completion of the entire grievance process***: \_\_\_\_\_

B - List each subscriber grievance included in "A" above (attach additional pages if necessary).

	<u>Subscriber Name, Address and Telephone Number</u>	<u>Nature of Grievance</u>  (Authorizations, Out of Plan Services, Reimbursement, etc.)	<u>Contract Type</u>  (Commercial, Medicare, EPO, Medicaid, PPO, etc.)
1.			
2.			
3.			

4.			
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6.			
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11.			
12.			
13.			
14.			
15.			

C - List all outstanding grievances included in item B, above, that are being resolved through arbitration (attach additional pages if necessary).

	<u>Subscriber Name</u>	<u>Date Original Grievance Received</u>	<u>Date Submitted For Arbitration</u>
1.			
2.			
3.			
4.			
5.			

D - List all outstanding grievances included in item B that are being litigated in court (attach additional pages if necessary).

	<u>Subscriber Name</u>	<u>Date Original Grievance Received</u>	<u>Date Litigation Began and Case Number</u>
1.			
2.			
3.			
4.			

**The information contained herein is true and correct to the best of my knowledge.**

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_

Send report to:

Subscriber Assistance Program  
 Agency for Health Care Administration  
 2727 Mahan Drive, Mail Stop 26  
 Tallahassee, FL 32308

Form may be accessed online at: <http://ahca.myflorida.com/MCHQ/Consumer/SPSAP/forms.shtml>

**ADDENDUM FOR ADDITIONAL ENTRIES FOR SECTION B ABOVE:  
List each subscriber in "A"**

	<u>Subscriber Name, Address and Telephone Number</u>	<u>Nature of Grievance</u> (Authorizations, Out of Plan Services, Reimbursement, etc.)	<u>Contract Type</u> (Commercial, Medicare, EPO, Medicaid, PPO, etc.)
16.			
17.			
18.			
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**AGENCY FOR HEALTH CARE ADMINISTRATION**

**Subscriber Assistance Program**

**Quarterly Report Of Subscriber Grievances  
Non-Grandfathered Plans**

Managed Care Entity: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Reporting Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Reporting Period: **Year:** \_\_\_\_\_

- \_\_\_\_\_ January 1 to March 31
- \_\_\_\_\_ April 1 to June 30
- \_\_\_\_\_ July 1 to September 30
- \_\_\_\_\_ October 1 to December 31

Report should be submitted  
on a *calendar* quarter not  
a fiscal quarter.

A - Total number of formal subscriber grievances ***not resolved*** to the full satisfaction of the subscriber ***after completion of the entire grievance process***: \_\_\_\_\_

B - List each subscriber grievance included in “A” above (attach additional pages if necessary).

	<u>Subscriber Name, Address and Telephone Number</u>	<u>Nature of Grievance</u>  (Authorizations, Out of Plan Services, Reimbursement, etc.)	<u>Contract Type</u>  (Commercial, Medicare, EPO, Medicaid, PPO, etc.)
1.			
2.			
3.			

4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

C - List all outstanding grievances included in item B, above, that are being resolved through the Federal External Review process or arbitration (attach additional pages if necessary).

	<u>Subscriber Name</u>	<u>Date Original Grievance Received</u>	<u>Date Submitted For Arbitration</u>
1.			
2.			
3.			
4.			
5.			

D - List all outstanding grievances included in item B that are being litigated in court (attach additional pages if necessary).

	<u>Subscriber Name</u>	<u>Date Original Grievance Received</u>	<u>Date Litigation Began and Case Number</u>
1.			
2.			
3.			
4.			

**The information contained herein is true and correct to the best of my knowledge.**

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_

Send report to:

Subscriber Assistance Program  
 Agency for Health Care Administration  
 2727 Mahan Drive, Mail Stop 26  
 Tallahassee, FL 32308

Form may be accessed online at: <http://ahca.myflorida.com/MCHQ/Consumer/SPSAP/forms.shtml>

**ADDENDUM FOR ADDITIONAL ENTRIES FOR SECTION B ABOVE:  
List each subscriber in "A"**

	<u>Subscriber Name, Address and Telephone Number</u>	<u>Nature of Grievance</u>  (Authorizations, Out of Plan Services, Reimbursement, etc.)	<u>Contract Type</u>  (Commercial, Medicare, EPO, Medicaid, PPO, etc.)
16.			
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**AGENCY FOR HEALTH CARE ADMINISTRATION  
SUBSCRIBER ASSISTANCE PROGRAM  
Managed Health Care Plan Response Form**

\*\*\*Please note, you must fill out this entire form. Any empty sections will delay the processing of this grievance. Also be sure to sign and date where indicated.

Managed Health Care Plan: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

(P.O. Box or Street & Suite Number)

\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
(City) (County) (State) (Zip Code)

Contact Person: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Email Address: \_\_\_\_\_ Fax Number: ( ) \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_

Subscriber's Mailing Address: \_\_\_\_\_

(P.O. Box or Street & Apartment #, City, State, Zip Code)

Name on Subscriber's contract, if different than Subscriber: \_\_\_\_\_

Group Number: \_\_\_\_\_ Member Number: \_\_\_\_\_

Group Name: \_\_\_\_\_ Group Size: \_\_\_\_\_

Effective Date of Coverage: \_\_\_\_\_

Please select one of the following:

- Commercial-not subject to Fed. External Rev.  Medicaid  Medicaid Reform  Medicare  
 Other \_\_\_\_\_

**Indicate Plan Category:**

- \_\_\_\_\_ Health Maintenance Organization  
\_\_\_\_\_ Exclusive Provider Organization (EPO)  
\_\_\_\_\_ Prepaid  
\_\_\_\_\_ EPO with Point of Service  
\_\_\_\_\_ EPO with Indemnity  
\_\_\_\_\_ Provider Service Network  
\_\_\_\_\_ Other: \_\_\_\_\_

**Indicate Nature of Grievance:**

- \_\_\_\_\_ Quality of Care  
\_\_\_\_\_ Formulary  
\_\_\_\_\_ Medical Necessity  
\_\_\_\_\_ Pre-Existing Condition  
\_\_\_\_\_ Excluded Benefit  
\_\_\_\_\_ Financial (billing, contract coverage, etc.)  
\_\_\_\_\_ Eligibility (Enrollment/Disenrollment)  
\_\_\_\_\_ Non-authorized services  
\_\_\_\_\_ Out-of-Network services  
\_\_\_\_\_ Experimental/Investigational/Unproven  
\_\_\_\_\_ Other: \_\_\_\_\_

Describe the Subscriber's grievance (use additional pages if necessary): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Investigation involved and findings: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Identify by statute and/or contract provision, justification for the final disposition: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

How would the Health Plan like to see this matter resolved? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Have all levels of the Health Plan's grievance procedure been completed?     \_\_\_ Yes     \_\_\_ No

Were the Department of Financial Services/Office of Insurance Regulation or the Agency for Health Care Administration previously involved in this grievance complaint?     \_\_\_ Yes     \_\_\_ No

Has this grievance been submitted to an arbitrator for resolution?     \_\_\_ Yes     \_\_\_ No

Has this grievance been litigated in any court of law?     \_\_\_ Yes     \_\_\_ No

If applicable, has beneficiary requested a Medicaid Fair Hearing?     \_\_\_ N/A     \_\_\_ Yes     \_\_\_ No

Please complete this form and provide all pertinent documentation required which will support the health plan's denial. Return to:

Agency for Health Care Administration  
Subscriber Assistance Program  
2727 Mahan Drive, Mail Stop 26  
Tallahassee, Florida 32308  
Fax: (850) 413-0900

**The information contained herein is true and correct to the best of my knowledge.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print / Type Name:** \_\_\_\_\_

**Title:** \_\_\_\_\_