

**Enhanced Benefits Accounts Program
Frequently Asked Questions
FAQ#1 September 12, 2006**

I. Program Operation

Q. The Panel indicated that the first set of "credit" data will be available November 1st. Is this when the state intends to distribute the first batch of credit statements? Is this when the database will be available? Please clarify.

A. The Health Plans will have access to credit data, if they choose, sometime in the near future. Initially this data will only be available to AHCA staff and Enhanced Benefits Account (EBA) Call Center staff. The first credits to individual accounts will occur on November 1st using information reported by health plans on October 10th. Statements of balance will be mailed to the enrollees after the credit to the account occurs. The database will be available and updated with the reported data and credit data to AHCA staff and EBA Call Center staff beginning November 1, 2006.

Q. The Panel referred to a "decision tree" in terms of answering questions from members with the plans being the single/initial point of contact; but thereafter certain calls could be redirected to the dedicated EB phone number. As such, the panel referenced FAQ documents that would be provided explaining this process. When will this be made available to the plans?

A. Enrollees will be given contact information that may be used to reach the Enhanced Benefits Account call center, which is responsible for answering enrollees' questions related to the Enhanced Benefits Account program and their individual accounts. The Agency is drafting the script that will be used by call center staff in assisting enrollees. As the Agency compiles a list of the enrollees' frequently asked questions, these answers will also be provided to call center staff.

Enrollees may still call the plans, and the plans are directed to assist their members to the best of their ability regarding the Enhanced Benefits Account Program. The Agency will provide the health plans with a decision tree to guide the communication between the plan's customer service representative and the member. This will help the customer service representative to determine early in the communication process if the Health Plan will be able to assist the member or if the member should be referred to the EB call center.

The narrative "script" with a "decision tree" is in the development process and working drafts will be provided to the plans by Friday September 15, 2006.

Q. Does the Panel intend to provide any training information or materials that could be used to train plan intake staff (e.g. CD Rom and PowerPoint being created by the Rx Unit for pharmacies)?

A. Most enrollee calls regarding the Enhanced Benefits Account program and individual accounts will be handled by the Enhanced Benefits call center. Enrollees may still call the plans, and the plans are directed to assist their members to the best of their ability. The Agency is drafting materials that will be used by call center staff. This information can be shared with plans for use in training their customer service staff.

Training materials for pharmacies are in the final stages of development and will be posted on the Agency's website for downloading. Finally, the Agency will work with plans to develop a brochure and letter for all network and non-network providers regarding the program, their responsibilities and completion of the EB Universal Form.

Q. What happens when the enrollee exceeds the maximum EB credit?

A. When an enrollee reaches \$125.00 for the year, no additional credits will be applied to the account. Additional healthy behaviors submitted to the Agency in the monthly file will be denied credit. A denial reason will appear in the database for these behaviors.

Q. Are the plans responsible for enrollee debit balances if they exceed their credit balances?

A. Pharmacies will be able to view the available balance in the enrollee's account when the enrollee purchases a health-related OTC product and the claim is submitted and adjudicated. Once a member uses the total credit balance, no additional purchases will be approved using the enhanced benefit account. The claims will deny at the pharmacy level with the response in the denial that shows a balance of \$0.00

Q. If an enrollee accesses a service from a non-contracted community provider that provides non-Medicaid covered services, is the provider reimbursed or is the member responsible?

A. In general, if a member chooses to see a provider that is not a part of the plan's network, the enrollee is responsible for the cost of the service. However, in some instances, plans may have provisions to pay for covered services that are provided by out of network providers. If the plan covers the service and the service is an approved healthy behavior, the plan must report the behavior in the monthly report using the appropriate CPT or EB codes.

If a member chooses to receive a service that is not covered by the plan, the enrollee is responsible for the cost of the service. Reimbursement will not be provided for these services. If the service is an approved healthy behavior, and the plan has received a completed and signed EB universal form, the plan must report the behavior in the monthly report using the appropriate EB code.

Q. Will health plan customer services staff have access to the credit/debit information that resides in an oracle database? Is so, by what means, (i.e. web, direct access etc.)

A. Yes, plans may choose to have access to credit/debit information that resides in the Enhanced Benefits Information System (EBIS) database in the near future. Since enrollee questions regarding their individual Enhanced Benefits Accounts will be handled by the Enhanced Benefits call center, plans will not need access to this data immediately.

The database will be accessible through the web. Additional details regarding the database will be provided by the Agency in the near future.

Q. Will AHCA provide a list of non-network community providers that are certified as an acceptable provider?

See A. for the next question.

Q. Will the Agency have a listing of approved vendors that the members can use for those behaviors that are not covered by the Plan? If so, will the Plan be given the listing of approved vendors?

A. Enrollees may chose to participate in any structured programs in their community that provide access to an approved healthy behavior. A structured program is defined as follows:

“A structured program is any program with defined goals and or milestones that is located in a facility that is accessible to the public that provides information, guidance, and or assistance for specific behaviors”.

As information is collected on the types and locations of programs that offer structured programs, the Agency will consider listing those providers on the website. However, the Agency will not certify providers as acceptable providers at this time.

Q. Is the health plan expected to promote the Enhanced Benefit Program to enrollees?

A. The Agency expects the plans to provide information to enrollees regarding the Enhanced Benefits Account Program. No later than September 1, 2007, the Health Plan’s Member Handbook must include information regarding the Enhance Benefit Account program. Additional information and direction will be provided to the plans.

Q. How will the members receive their credits?

A. The following description is the process in which credits will be processed.

- The recipient participates in an approved healthy behavior
- The claim or universal form is submitted to the recipient’s current health plan
- The health plan processes the claim or EB Universal Form
- The Health Plan generates a monthly report for claims paid during the prior month or EB Universal Forms that were received during the prior month
- The Health Plan submits the monthly report to the Agency by the 10th calendar day each month
- The Agency uploads the reports and applies eligibility, credit, and annual limit edits to the records submitted
- Approved records are then priced for the appropriate credit amount
- The Agency submits a file to the Fiscal Agent to update the accounts to reflect the earned credits

- The credit upload to the Fiscal Agent is scheduled for at least once per month
- The Fiscal Agent generates and mails letters that contain information about the program and the current balance of the account
- Recipients are then able to access their accounts using their Medicaid Gold Card at Medicaid Participating Pharmacies to purchase approved health related products and supplies.

Q. Is the state going to regulate where enrollees can redeem their points and what they can be redeemed for?

A. Credit balances may be used to purchase items on the approved list of health related products and supplies at any Medicaid participating pharmacies. For the complete listing of these items please visit our web site at:

http://ahca.myflorida.com/Medicaid/medicaid_reform/enhab_ben/enhanced_benefits.shtml

Q. Members are going to be asking questions regarding which health related supplies they can purchase. Will the Agency be supplying a complete list to the plans of approved OTC items? If the listing changes how will the Plans be advised?

A. The list of approved items for purchase is available on the website.

http://ahca.myflorida.com/Medicaid/medicaid_reform/enhab_ben/enhanced_benefits.shtml

Q. If the member selects an item not on the health related supply list & the pharmacy calls the Plan, the Plan will advise the Pharmacy to call the Agency's Pharmacy dept., correct?

A. The pharmacies may contact or refer the member to the ACS choice Enhanced Benefits center for information related to approved health related products and supplies. Members may only purchase items on the approved list.

Training material is in development for pharmacies that will provide program information and technical processing details. Processing assistance will be available to the pharmacies through the ACS technical helpdesk that they refer their questions for other Medicaid claims processing questions.

Q. How should the Plans respond if a member submits the EB Universal Form completed by a non-Agency approved vendor? Does the Plan send a letter to the member?

A. Enrollees may chose to participate in any structured programs in their community that provide access to an approved healthy behavior. A structured program is defined as:

“A structured program is any program with defined goals and or milestones that is located in a facility that is accessible to the public that provides information, guidance, and or assistance for specific behaviors”.

As information is collected on the types and locations of programs that offer structured programs, the Agency will consider listing those providers on the website. However, the Agency will not certify providers as acceptable providers at this time. If the plan receives an incomplete or an unsigned EB Universal Form, the health plan should notify the enrollee that the form is incomplete or unsigned and will not be reported for credit until it has been completed or signed.

II. EB Universal Form

Q. Will an online version of the EB Universal Form be created so that members and providers may fill out the form online and submit electronically? If yes, will the State maintain these records?

A. The Agency has no plans at this time to create an online version of the EB Universal form for electronic submission. Health Plans may set up or use an existing secure FTP site to receive completed EB Universal Forms. The Health plan is required to maintain these records. The Agency will not maintain these records.

Q. Please confirm that the EB Universal Forms submitted by member or providers may be maintained electronically to satisfy the five year storage requirement.

A. Enhanced Benefits Universal Forms must be maintained by the plans for a period of 5 years and must be maintained in a place and manner that will allow for easy reference or submission to the Agency upon request. These files may be maintained using electronic imaging technology or hard copies that are easily accessible by request.

Q. Can the utilization of approved Healthy Behaviors provided by the Health Plan that do not have a CPT code be tracked electronically without completing the Enhanced Benefit Universal Form for each recipient and occurrence?

A. Disease management participation for programs administered by plans may be reported directly to the Agency in the appropriate file format and an Enhanced Benefits Universal Form will not be required, although plans must keep internal records as to such participation and must be maintained by the plans for a period of 5 years and must be maintained in a place and manner that will allow for easy reference or submission to the Agency.

Q. Will AHCA still consider removing the "OTHER" category on the EB Universal Form as we believe this will cause undue confusion?

A. At this time the "other" category is intended to capture those behaviors that are considered success measurements for certain other healthy behaviors. We are considering removal of the "other" category once EB codes have been assigned to these behaviors.

Q. Please confirm that MCOs will be held harmless for information supplied by members and providers on the EB Universal Form (i.e., not required to validate self reported information for purposes of determining fraud).

A. The health plan is responsible for collecting and submitting the data on the EB Universal Form to the Agency. The health plan is not required to verify participation in the non-covered service, or verify that the program is a valid structured program unless the program is sponsored by the health plan. The plan is responsible for checking the form for completeness, including valid Medicaid Enrollee ID number and signatures of both the enrollee and the provider/program sponsor.

Q. Is it the State's intention to have the plans "code" the EB Universal Form report submission based on the newly created "EB codes" presented on the form?

A. Yes, the codes on the EB Universal Form, which have been provided in the health plan policy letter, must be used to prepare the health plan enhanced benefits monthly report using the same file layout used for reporting behaviors with CPT codes.

Q. Regarding the universal enhanced benefit form, who maintains the form and how is it submitted to the Agency?

A. Enrollees will be required to submit the EB Universal Form to their health plan. The health plan has been directed to collect the EB Universal Form and report the required data elements from the form to the Agency on a monthly basis in the electronic file format provided in the health plan policy letter.

Q. How will enrollees get the EB Universal Form?

A. The Enhanced Benefits Universal Form (EB Universal Form) will be mailed by the Agency to enrollees in their Enhanced Benefit welcome packet. The packet will contain a letter explaining the program, a brochure, and a copy of the EB Universal Form. In addition, the form is available on the Medicaid Reform website and by request by contacting the Enhanced Benefit Call Center.

Health Plans may also provide a link to the form on their website.

Q. Does the form drive the credit for the benefit? Or does the claim?

A. The enrollee will earn credits for approved healthy behaviors that do not have a CPT code or are not provided by the health plan, which are reported on the EB Universal Form. Only those behaviors identified on the form are eligible for credit using the EB Universal Form. Any claim that is covered by the plan and is billed using a CPT code can be tracked using the paid claim. In those cases, enrollees will earn credits based on paid claims for approved healthy behaviors reported by the plans.

Q. Please describe the purpose of the Enhanced Benefit EB Universal Form. Is it a claim form or a verification of services?

A. The EB Universal Form is viewed as a claim for the specified behaviors. These claims are not eligible for reimbursement. The form was created to provide a way to track and document participation in approved healthy behaviors that may not be provided by the health plan, and do not have CPT codes.

III. Reporting Requirements

Q. The Panel has indicated a dedicated telephone number will be setup for the Enhanced Benefit Program. Will this number be made available to the Plans only or will members also have access? Will this number be used for troubleshooting technical issues or only for member directed questions? Please clarify.

A. A dedicated phone number will be setup for the EB call center as the single point of contact for enrollee assistance. This phone number will be available to the plans; however, the operators will be trained to respond primarily to beneficiary question and will not be able to answer technical questions related to reporting. Any technical questions should be forwarded to the Agency at: HUDSONS@AHCA.MYFLORIDA.COM

The Health Plans will be responsible as the lead contact for questions related to reporting healthy behaviors submitted through claims and on the EB Universal Forms. These questions may be handled through the Plan's customer service or other approved means.

Q. Are services that are associated with industry standard codes (i.e. CPT4, HCPCS, etc) to be submitted on an industry standard claim form (HCFA/UB?).

A. The Enhanced Benefits Account program and report will not replace any claims processing or other reporting criteria that are required of the health plans. The codes that should be extracted from claims history are Current Procedural Terminology (CPT) codes, Generic Code Numbers (GCN), National Drug Code Numbers (NDC) and EB Codes. The EB codes have been created by the Agency for the purpose of the Enhanced Benefits Account program and report only. The plan must submit the standard codes for the approved activities in the format specified by the Agency.

Q. Who is to receive the Enhanced Benefit reports at AHCA? Will this be an FTP submission?

A. The reports will be submitted using a secure FTP site. Additional information regarding the submission of these reports is provided in General Amendment I.

Q. Please confirm the report file format - Microsoft Excel or delimited text file? Please re-confirm the file layout for both the CPT and EB codes submissions.

A. The file layout is a fixed formatting layout with specified fields, lengths and types.

Enhanced Benefits Report Format

Plan ID	Character, 9 bytes
Recipient ID	Character, 9 bytes
Date of Birth	CCYY-MM-DD
Procedure Code	Character 5
Date of Paid Claim	CCYY-MM-DD
NDC	Character 11
GCN	Character 5
Quantity	Numeric 4
Day Supply	Numeric 3
Date of Service	CCYY-MM-DD

Q. Should the report be driven by claim paid date, claim date of service, or claim receipt date?

A. Report Scope:

Behaviors reported using the file layout should meet the following criteria for claims based data:

- The claim must be a paid claim
- All dates of service are on or after September 1, 2006
- Date of Service (DOS) must be within an eligibility span for which the recipient was or is enrolled in the reporting reform plan (NO claims paid with DOS for non-reform eligibility and enrollment period should be included)
- Claim must include an approved CPT, EB, or GCN/NDC code

Additional clarification and requirements regarding the tracking and reporting of claims information from the Health Plans' capitated providers and the EB Universal Forms will be provided by the Agency in the near future.

Report Phase-In Schedule:

October 10, 2006 - Minimum of CPT codes (EB and GCN/NDC if available)

November 10, 2006 – Minimum of CPT and EB codes (GCN/NDC if available)

January 10, 2006 – All codes: CPT, EB and GCN/NDC

Q. Does the Agency only want paid claims included on the report – not denied or pended claims or encounters?

A. For this report, the Agency is requesting only paid claims and information from completed and signed EB Universal Forms should be included.

Q. Does the Agency want a count of claims with each procedure number, or do they want detail – i.e., the individual claim TCN numbers?

A. Claims level data is most useful to the Agency in determining those healthy behaviors in which the enrollee has participated in. The file layout of the report will allow only one claim to be documented per line.

Q. How will the report be sorted – by date, CPT code, enrollee ID number, or other data element?

A. The plan will not be required to sort the report.

Q. The state has made reference to "NDC" codes (11 characters) as data to be provided in the Enhanced Benefit Reports. We are unclear why this reference is included for submission. It was our understanding that certain pharmacy items were "approved" for purchase with the Gold Card credit. As such, is it the State's intent that MCOs provide this data for purposes of debiting "credits" or dollars from those earned? If yes, please clarify the parameters for this. If not, please clarify the use of this pharmacy data.

A. Enrollees can earn credits for "compliance with prescribed medications" therefore the health plan is required to submit claims information identifying those drugs that the patient is taking as prescribed. Paid prescription claims data includes the Generic Code Number (GCN) or National Drug Code Number (NDC). Plans will be able to submit the GCN or NDC number as part of the report in identifying claims for prescription drugs. For the complete listing of these codes please visit our web site at:

http://ahca.myflorida.com/Medicaid/medicaid_reform/enhab_ben/enhanced_benefits.shtml

Enrollees may use earned credits to purchase health related supplies over the counter at Medicaid participating pharmacies. The list of products and supplies approved for purchase using the credit balance in an enhanced benefits account is a separate list of NDC/UPC codes. The health plans are not required to track this list or purchases made by enrollees. The Agency will process and track these claims.

Q. Please specify the health plans reporting requirements including format, frequency, codes, enrollee.

A. The report is due to the Agency by the 10th calendar day each month, beginning October 10, 2006. The report should contain paid claims for the prior month, with dates of service beginning with the enrollee enrollment date into a reform plan. No dates of service prior to September 1, 2006, are eligible for credit and should not be on the report.

The records captured on the report should be paid claims that contain the approved CPT codes or GCN/NDC. The EB Universal Forms received during the prior month should also be added to the report using the same file layout and the EB codes established for this program.

Q. If CPT codes 9920-99205 OV; and 99211-99215 OV are used by providers to bill for services which are not healthy behavior related, what are the required diagnosis codes to be used, specific to these procedure codes? There is a procedure code for "keeps all primary care appointments". Since plans are required to report off of paid claims, how can we use this code if "keeping an appointment" is neither a billable service nor an encounter?

A. Plans are required to report healthy behaviors for CPT codes listed above, if a claim is paid, indicating the enrollee has had an office visit. The Agency will assume that if an approved CPT code for an office visit is paid, the member has kept the appointment.

The behavior name "Keeps all primary care appointments" is the name of the behavior only. The name is targeted to the enrollees and is worded in a manner to assist in explaining the behavior. For reporting purposes and for the understanding of the health plans, the Agency understands that there is no current way to know when an appointment is made and kept and it is therefore assumed by the Agency that if a CPT is billed and paid, the healthy behavior has been completed.

Q. In the panel meeting, there was some reference to a delay until late November regarding the NDC codes submission. Please clarify the timeline and details for this delay.

A. The GCNs/NDCs must be included on the report by January 10, 2007. This date marks the end of the first 90 day period for which compliance with prescribed medications could be measured. The healthy behavior associated with compliance requires 90 days of continuous compliance. There is no need to submit prescription claims information prior to the opportunity for 90 days of compliance. If the health plan chooses to delay the reporting of the GCN/NDC until the January report, all claims paid beginning in September through the month prior to the report when the GCNs are added should be included.

Q. How will the Plan be required to submit the information on the EB Universal Form? At one point we were under the impression that all behaviors were to be reported through the layout & most recently we understood that the form should be electronically submitted to the Agency as an image document.

A. Information from the EB Universal Form will be included in the monthly report using the same file format as other healthy behaviors with CPT codes. This file format was provided in the health plan letter. The EB Universal Form should not be submitted to the Agency as an image document. The plan will maintain the EB Universal Form as a record to verify the activity was completed.

Q. The CPT codes required for reporting is different from the 1st listing the Plans received – can the Plans get a final listing?

A. A copy of the final CPT code is available on the website.

http://ahca.myflorida.com/Medicaid/medicaid_reform/enhab_ben/enhanced_benefits.shtml

Q. What NDC codes are required?

A. Plans may report either a GCN or an NDC. The complete listing of these codes is available on our website at:

http://ahca.myflorida.com/Medicaid/medicaid_reform/enhab_ben/enhanced_benefits.shtml

Q. The transmittal reads: The EB Universal Form will be submitted by the enrollee to the Health Plan to document participation in a healthy behavior that does not have a standard procedure code.” Question: If there is no standard procedure code what gets reported on the electronic file?

A. By standard procedure code, the Agency is referring to CPT codes or nomenclature used by the medical industry. For the purpose of this program, EB codes have been created. The health plan should report using these codes for EB Universal Forms. The complete listing of these codes is available on our website at:

http://ahca.myflorida.com/Medicaid/medicaid_reform/enhab_ben/enhanced_benefits.shtml

IV. Pharmacy Training

Q. What education/training will be or has been provided to the pharmacies? Have they been trained on the Agency’s system in order to report the usage of the credits and view credit limits? Have they been advised that this is separate from the Hernandez Settlement issues? Have they been advised that this is different from the Plan’s OTC benefit?

A. Notices and power point presentations are in development. The Agency is working to provide training and notices to pharmacies in September. Pharmacies will continue to use the current system they use for Medicaid FFS claims to bill for purchases. There will be changes to the NDC input line which is detailed in the training materials. Finally, use of earned credits to purchase OTC items is not related to the Hernandez Settlement. Pharmacies will be advised of the difference in program operation in the training materials.

Q. What pharmacies can the members utilize? Prior to the Plans being involved it appears the members could utilize any pharmacy contracted with the Agency – Is that still the case or will the members have to utilize the pharmacies contracted through the Plans?

A. For the purposes of the Enhanced Benefit Account program only, members can utilize any Medicaid participating pharmacy.

SPECIAL NOTE: The Agency has posted many documents related to the Enhanced Benefits Account Program such as the lists of codes, behaviors, and the most recent letter to the Health Plans on the Florida Medicaid Reform website. In addition to the above FAQ, the documents on the website contain valuable information related to the operations and reporting requirements for the Enhanced Benefits Account program. The Agency encourages all Health Plans to visit the Website to obtain information.

http://ahca.myflorida.com/Medicaid/medicaid_reform/enhab_ben/enhanced_benefits.shtml