Pharmacy Provider Revalidation

Frequently Asked Questions

Updated: April 6, 2021

1. **Why do I have to revalidate?**

   To remain in compliance with Title 42 Code of Federal Regulations (CFR) Section 455.414, HHSC revalidates all providers' enrollment, regardless of provider type, at least every five years. Revalidation includes conducting a full screening according to the provider's level of risk for fraud, waste, and abuse. CMS designates pharmacies as a limited risk. The screening includes verifying the pharmacy meets applicable Federal regulations or State requirements, conducting license verifications, and conducting database checks to ensure the pharmacy continues to meet the enrollment criteria.

2. **What information do I need to submit?**

   Revalidation includes the submission of a Pharmacy Enrollment Application, supporting documents, and an application fee. Pharmacy Providers can complete the provider enrollment, re-enrollment or revalidation process using the Provider Enrollment and Management System (PEMS). The following link contains a step by step guide for completing the enrollment process as a Vendor Drug Program (VDP) pharmacy provider in the Provider Enrollment and Management System (PEMS).

3. **When should I submit my application?**

   After receipt of all information necessary to process the application, the entire application process can typically take up to 60 days[i]. This may be extended in special circumstances. Requests for exceptions to the enrollment process, risk category, and provider types that require additional state approval may extend the length of the application process.

4. **Will I be notified when it's time to revalidate?**

   Yes. TMHP will send a notice 120 days before your enrollment ends. TMHP will communicate with pharmacies via email and updates to the VDP and TMHP websites regarding due dates based on state and federal flexibilities.

5. **What happens if I don't revalidate on time?**

   Failure to revalidate on time may result in disenrollment from Texas Medicaid and your claims and prior authorization requests will be denied. Pharmacies disenrolled from Medicaid must submit a new application and pay an application fee.

6. **How often do I have to revalidate?**

   You are required to revalidate every five years. However, HHSC has the discretion to require revalidation on a more frequent basis. Refer to Screen Risk Categories (42 CFR Subpart P 424.518) for more information.

7. **Is revalidation the same as re-enrollment?**

   No. Re-enrollment occurs when you have been disenrolled, terminated, deactivated, or otherwise removed as a Medicaid provider and seek to reestablish enrollment. Re-enrollment is a new enrollment and HHSC will follow the same process it would if you were newly enrolling. Revalidation renews Texas Medicaid enrollment for actively enrolled providers without interrupting their enrollment status

   > Enrollment Deactivation/ Deactivate - means that the provider’s billing privileges were stopped but can be restored upon the submission of updated information.
   >
   > Termination means a provider’s active enrollment status with the State Medicaid Agency has been terminated. Only providers who were in an active enrollment status qualify as terminated providers.

8. **Who can I contact if I have any questions regarding my application?**

   General Inquiries: 1-800-925-9126 (Option 3) Provider Enrollment can provide assistance with enrollment applications, updates to new and existing provider accounts, and enrollment policy. Agents can answer questions about maintenance of provider accounts, completing a Texas Medicaid program application, and policies that affect enrollment.

   Additionally, providers can send an email to TMHP Email Contact (from the dropdown email subject category menu select provider enrollment)

9. **What kind of correspondence the provider should expect to receive for any deficiencies that are found?**

   Providers will receive email notifications when messages or deficiency notices about their applications are posted online in PEMS. The messages can be viewed on the secured access portion of the website. Providers may opt out of email communication and receive messages or deficiency letters by mail.

Screen Risk Categories

1. **What does a screening according to my level of risk for fraud, waste, and abuse mean?**

HHSC is required to screen all new enrollment applications, including applications for a new practice location, change in ownership, re-enrollment, and revalidation based on a categorical risk level of limited, moderate, or high. If you fit within more than one risk level, the highest level of screening is applicable. The Centers for Medicare and Medicaid Services (CMS) and HHSC designate categorical risk levels for providers based on their potential for fraud, waste, and abuse.

2. Can my risk level change?

Yes. As provided in 42 CFR §455.450(e), HHSC must adjust the categorical risk level of a particular provider from limited or moderate to high when any of the four situations occur:

- HHSC imposes a payment suspension on a provider based on a credible allegation of fraud, waste, or abuse. The provider's risk remains "high" for 10 years beyond the date of the payment suspension.
- A provider has an existing State Medicaid Plan overpayment identified upon applying for enrollment or revalidation. The risk remains "high" while the provider continues to have an existing overpayment. An overpayment meeting the criteria to bump a provider to "high" risk is $1,500* or more and all of the following:
  - Is more than 30 days old
  - Has not been repaid at the time of application filing
  - Is not currently being appealed
  - Is not part of a State Medicaid Agency-approved extended repayment schedule for the entire outstanding overpayment
  - Note: The $1500 threshold is an aggregate of all outstanding debts and interest, to include the principal overpayment balance amount and the accrued interest amount for a given provider.
- The Office of the Inspector General (OIG) or another state's Medicaid program has excluded the provide within the previous 10 years.
- HHSC or CMS in the previous six months lifted a temporary moratorium for the particular provider type and a provider prevented from enrolling based on the moratorium applies for enrollment as a provider at any time within six months from the date the moratorium was lifted.

3. How does my risk category affect revalidation?

CMS bases screening activities on the categorical risk level of the provider. The following table shows the screening activities based on the risk level.

Risk Level	Screening Activities
Limited	• Verifying the provider meets applicable Federal regulations or State requirements. • Conducting license verifications. • Conducting federal and state database checks.
Moderate	• All Limited screening activities. • Site visits in accordance with 42 CFR §455.432.
High	• All limited and moderate screening activities • Fingerprint-based criminal background checks for all providers and associated owners with 5 percent or more direct or indirect ownership in accordance with 42 CFR §455.434. Refer to the Texas Medicaid FAQ document for more information.

Application Fee

1. **How much is the application fee?**

   The amount of the application fee is subject to change every calendar year. CMS publishes next year's application fee in the Federal Register 60 days before the new calendar year.

   - The fee is $599.00 for applications submitted between Jan. 1 and Dec. 31, 2021.

2. **Do I need to pay the application fee?**

   The pharmacy must pay the application fee at the time of entering into PEMS. Pharmacies pay the fee for all new enrollment applications, including applications for a new practice location, change in ownership, re-enrollment, and revalidation. You may not have to pay if you meet one of the following conditions:

   - Your pharmacy enrolled and paid the application fee in another state's Medicaid program. You must submit proof of payment (such as a receipt) when submitting your application.
   - Your pharmacy enrolled in Medicare. You must submit proof (such as a receipt) when submitting your application.
   - You are requesting a hardship exception. Refer to 42 CFR Subpart P 424.514. CMS reviews and approves requests on a case-by-case basis.

[i] Business days and holidays are accounted for in business day calculations.