TEXAS Health and Human Services

# Pharmacy Provider

## *Frequently Asked Questions*

**Updated**: August 20, 2021

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

   To remain in compliance with Title 42 Code of Federal Regulations (CFR) §455.414, all pharmacy provider enrollments, regardless of provider type, are revalidated at least every five years. Revalidation includes conducting a full screening according to the provider's level of risk for fraud, waste, and abuse. Centers for Medicare and Medicaid Services (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 revalidation process using the Provider Enrollment and Management System (PEMS). A step-by-step guide for completing the enrollment process as a pharmacy provider is available on tmhp.com.

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

   The revalidation process requires a minimum of 30 business days once TMHP receives your completed application. TMHP accounts for business days and holidays in the calculations, and TMHP may require additional time if further documentation is needed. 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. Pharmacies cannot apply 120 days before your enrollment ends.

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 remind pharmacies by email located in your TMHP Account message dashboard.

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

   Failure to revalidate on time may result in disenrollment from Texas Medicaid, which will result in claims denials. Pharmacies disenrolled from Medicaid must submit a new reenrollment application and pay an application fee.

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

   You are required to revalidate every five years. 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 reenrollment?**

   No, reenrollment occurs when you have been disenrolled, terminated, deactivated, or otherwise removed as a Medicaid provider and seek to reestablish enrollment. Reenrollment is considered the same as new enrollment, and HHSC follows the same process if you were newly enrolling.

   Revalidation renews Medicaid enrollment for actively enrolled providers without interrupting their enrollment status.

   Enrollment Deactivation means the provider's billing privileges were stopped but can be restored upon submitting updated information.

   Termination means HHSC terminated the provider's active enrollment status with Medicaid.

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

   For general inquiries, call 1-800-925-9126 and select option 3 for provider enrollment. Agents can assist with enrollment applications, updates to new and existing provider accounts, and enrollment policy. Additionally, providers can send an email to TMHP. Refer to the Contact Us page at secure.tmhp.com/accountActivation/ContactUsEmail/Index and select Provider Enrollment from the dropdown.

9. **What kind of correspondence should providers expect to receive for any deficiencies?**

   You will receive an email notification when TMHP updates information about your applications in PEMS and you can view the messages on the secured access portion of the website.

## 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, reenrollment, and revalidation based on a categorical risk level (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. HHSC must adjust the categorical risk level of a provider from limited or moderate to high when any of the four situations below occur. Refer to "Screening Levels for Medicaid Providers" 42 CFR §455.45(e) for more information.

- 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
  - It 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, including 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 agency lifted the moratorium.

## 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<br>• Conducting license verifications<br>• Conducting federal and state database checks |
| Moderate | • All limited screening activities, above<br>  • Site visits in accordance with " Site Visits " (42 CFR §455.432) |
| High | • All limited and moderate screening activities, above<br>  • Fingerprint-based criminal background checks for all providers and associated owners with 5 percent or more direct or indirect ownership in accordance with "Criminal Background Checks " (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 to TMHP at the time you submit your application in PEMS. Pharmacies pay the fee for all new enrollment applications, including applications for a new practice location, change in ownership, reenrollment, 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 show proof of enrollment.
   - 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.