

Texas Vendor Drug Program **Pharmacy Provider Procedure Manual**

Eligibility

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The Pharmacy Provider Procedure Manual (PPPM) is available online at txvendordrug.com/about/policy/manual.



TEXAS
Health and Human
Services

*Medical and
Social Services*

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1 Identification Numbers

1.1 Medicaid

Medicaid is a jointly funded state-federal health care program, established in Texas in 1967 and administered by the Health and Human Services Commission (HHSC). In order to participate in Medicaid, federal law requires states to cover certain population groups (mandatory eligibility groups) and gives them the flexibility to cover other population groups (optional eligibility groups).

All people who are determined to be Medicaid eligible are first enrolled as fee-for-service. Specific groups are then enrolled in managed care based on criteria such as age, location, and need.

1.1.1 Fee-for-Service

Fee-for-service, or traditional, Medicaid is for people who cannot be in managed care. Pharmacy claims must be submitted with the values identified in Table 1. Refer to the "NCPDP B1 Transaction Billing Request" payer sheet for specific transaction, segment, and field requirements. Download the **VDP Pharmacy Provider Payer Sheets** from the "Downloads" page at txvendordrug.com/about/policy/payer-sheets.

Table 1 - Medicaid Pharmacy Claims Submission

Field Name	Field Number	Submitted Value
BIN Number	101-A1	610084
Processor Control Number	104-A4	DRTXPROD
Group ID	301-C1	MEDICAID

Pharmacy claims for newborns who have not had a Medicaid ID number assigned should not be submitted with the Mother's ID number. These claims may be submitted on the Pharmacy Claims Billing Request. Refer to the "Paper Claims" section in the [System Requirements](#) chapter of the PPPM for the Pharmacy Claims Billing Request (HHSC Form 1319). Download the **Pharmacy Claims Billing Request** from the "Downloads" page at txvendordrug.com/resources/downloads.

1.1.2 Managed Care

The type of Medicaid coverage a person receives depends on where the person lives and what kind of health issues the person has.

- **STAR** is Medicaid for children, newborns, pregnant women and some families and children. People in STAR get their services through health plans, also called managed care plans.
- **STAR+PLUS** is a Medicaid program for people who have disabilities or are age 65 or older. People in STAR+PLUS get Medicaid basic medical services and long-term services through a health plan, also called a managed care plan.
- **STAR Health** is a statewide, comprehensive healthcare system that was designed to better coordinate and improve access to health care for:
 - ▶ Children in Department of Family and Protective Services (DFPS) conservatorship (under age 18).
 - ▶ Young adults in CPS extended foster care (ages 18 through 20)
 - ▶ Young adults who were previously under DFPS conservatorship and have returned to foster care through voluntary foster care agreements (ages 18 through 20.)
 - ▶ Young adults eligible for Medicaid for Former Foster Care Children (FFCC) will continue coverage through the STAR Medicaid Managed Care plan of their choice from age 21 through the month of their 26th birthday.

Pharmacy providers should refer to the managed care organization's provider manual and policy materials. Refer to the [Managed Care](#) chapter of the PPPM for more information on contacting MCOs in your area.

1.1.3 Copayment Information

There are no prescription drug co-payments for Medicaid-eligible people.

1.1.4 Medicaid Eligibility Verification

Medicaid-eligible people may present the Medicaid Eligibility Verification (HHSC Form 1027-A) as evidence of Medicaid eligibility. While the form does not have a Medicaid ID number, it is an official state eligibility document that can be relied upon as proof of Medicaid eligibility until the person and/or family receives the Your Texas Benefits Card (refer to section 2.2 below). Medicaid numbers should be assigned within one month of the original presentation. Pharmacy staff are strongly encouraged to fill the prescription immediately and then submit the claim online as

soon as the Medicaid number is assigned. Pharmacy staff should refer to the formulary to ensure the drug is a covered Medicaid product.

1.1.5 Medicaid Presumptive Eligibility

Medicaid Presumptive Eligibility (PE) is a process that allows qualified hospitals (QH) and other qualified entities (QE) to determine if a Medicaid-eligible person can get short-term Medicaid. The Affordable Care Act (ACA) requires states to allow QH/QE groups that have gone through the qualification process to make PE determinations consistent with HHSC policies and procedures.

QH/QE staff will provide the person with the Short-term Medicaid Notice (HHSC Form H1266) if the person is determined to be presumptively eligible. Pharmacy staff may be presented with Form H1266. This form is not a substitute for the Medicaid Eligibility Verification (Form 1027-A) or the Your Texas Benefits Medicaid card. In order for a person to receive pharmacy benefits after receiving a Form H1266, the person should:

- Request a Medicaid Eligibility Verification (Form 1027-A) at an HHSC benefits office, or
- Print a Medicaid card at YourTexasBenefits.com.

To learn more about presumptive eligibility please visit TexasPresumptiveEligibility.com.

1.2 Children's Health Insurance Program

CHIP is health insurance designed for families who earn too much money to qualify for Medicaid, yet cannot afford to buy private health insurance. To qualify for CHIP, a child must be under age 19, a Texas resident, and a U.S. citizen or legal permanent resident.

All pharmacy claims for CHIP-eligible people are processed through the person's managed care organization. In addition, there is a copayment amount required for the majority of CHIP-eligible people. Pharmacy providers should refer to the managed care organization's provider manual and policy materials. Refer to the [Managed Care](#) chapter of the PPPM for more information on contacting MCOs in your area.

B1 transaction for CHIP submitted to VDP will reject but include a message that includes the name of the person's MCO. E1 transactions for CHIP submitted to VDP

will return only the name of the MCO. Refer to the [System Requirements](#) chapter of the PPPM for more information about the eligibility verification transaction.

1.3 Children with Special Health Care Needs Services Program

The CSHCN Services Program helps children with special health care needs in Texas improve their health, well-being, and quality of life. The program pays for medications, medical treatment, and equipment for eligible children with special needs from birth to 21 years of age and for people of any age with cystic fibrosis. It is not a Medicaid program.

1.3.1 Program eligibility

The program is available to people who:

- Live in Texas
- Are under 21 years old (or any age with cystic fibrosis)
- Have a certain level of family income
- Are diagnosed with a medical condition covered by CSHCN.
- Are expected to improve or become functionally independent as a result of treatment/services. Covered terminal conditions may be exceptions to this criteria.
- Have a medical problem that:
 - ▶ is expected to last at least 12 months;
 - ▶ will limit one or more major life activities;
 - ▶ Needs more health care than what children usually need; and
 - ▶ Have physical symptoms. This means that the program does not cover people with only a mental, behavioral or emotional condition, or a delay in development.

Questions about eligibility should be directed to the CSHCN Services Program.

1.3.2 Identification Form

Each person is assigned a unique six-digit program ID. These program ID numbers are generated sequentially by the program eligibility system, and appear on the eligibility forms that eligible people should take to the pharmacy. Pharmacy staff should convert the six-digit number to a nine-digit number to submit the claim online.

To convert for claim submission, add the number “9” to the beginning of the core six-digit program ID number, followed by “00” after the core program ID number, as shown in Table 2. Failure to correct the cardholder ID prior to transmission will result in NCPDP error code 52 (“Non-matched Cardholder ID”).

Table 2 - CSHCN Service Program ID Conversion

Assigned Program ID	Submitted Cardholder ID
123456	912345600

1.3.3 Pharmacy Claims Submission

Pharmacy claims must be submitted with the values identified in Table 3. Refer to the “NCPDP B1 Transaction Billing Request” payer sheet for specific transaction, segment, and field requirements. Download the **VDP Pharmacy Provider Payer Sheets** from the "Downloads" page at txvendordrug.com/about/policy/payer-sheets.

Table 3 - CSHCN Services Program Pharmacy Claims Submission

Field Name	Field Number	Submitted Value
BIN Number	101-A1	610084
Processor Control Number	104-A4	DRTXPROD
Group ID	301-C1	MEDICAID

1.3.4 Copayment Information

There are no prescription drug copayments for CSHCN-eligible people.

1.4 Kidney Health Care Program

The KHC program covers approximately 20,000 people with end-stage renal disease (ESRD). The program’s drug benefit assists with costs for 4 covered drugs per month and coordinates with Medicare Part D on deductibles, co-insurance amounts, and Part D “gap” or “donut hole” expenditures, where the person is responsible for 100 percent of drug costs. People eligible for Medicaid are not eligible for KHC drug benefits.

Benefits available to people enrolled in KHC are dependent on treatment status and eligibility for benefits from other programs such as Medicare, Medicaid, or private insurance, and availability of funds. This may mean that some people may not have a drug benefit. Program-eligible people should contact their social worker or call KHC at 1-800-222-3986 about their specific coverage.

1.4.1 Identification Card

KHC does not issue eligibility cards. People enrolled in KHC will receive an explanation of benefits (EOB) that indicates if they are eligible for the drug benefit, but updated EOBs are not issued on a regular basis or when drug benefits change. Pharmacy staff may contact the KHC program or the VDP Pharmacy Benefits Access Help Desk to verify eligibility. Refer to the [Contact Information](#) chapter of the PPPM for contact information, or refer to 2.1 below to learn about real-time eligibility verification methods.

1.4.2 Pharmacy Claims Submission

Pharmacy claims must be submitted with the values identified in Table 4. Refer to the "NCPDP B1 Transaction Billing Request" payer sheet for specific transaction, segment, and field requirements. Download the **VDP Pharmacy Provider Payer Sheets** from txvendordrug.com/about/policy/payer-sheets.

Table 4 - KHC Program Pharmacy Claims Submission

Field Name	Field Number	Submitted Value
BIN Number	101-A1	610084
Processor Control Number	104-A4	DRTXPRODKH
Group ID	301-C1	MEDICAID

1.4.3 Copayment Information

Pharmacy staff should contact the KHC Program for copayment information. The copay amount due is returned in the "Patient Pay Amount" field (505-F5) of the pharmacy paid claim response. Refer to the **Pharmacy Provider Payer Sheets** for information about values and field returned on the paid and rejected response transactions.

Pharmacy staff can perform an Eligibility Verification (E1) transaction to find the person's copayment amount. Refer to the [System Requirements](#) chapter of the

PPPM for information about claim transactions. Refer to the "Field Responses for an Accepted Eligibility Verification" in the **NCPDP E1 Transaction Accepted Response payer sheet** for further explanation about the response.

1.5 STAR Health

STAR Health is a statewide, comprehensive healthcare system designed to better coordinate and improve access to health care for:

- Children in Department of Family and Protective Services (DFPS) conservatorship (under age 18).
- Young adults in CPS extended foster care (ages 18 through 20)
- Young adults who were previously under DFPS conservatorship and have returned to foster care through voluntary foster care agreements (ages 18 through 20.)
- Young adults eligible for Medicaid for Former Foster Care Children (FFCC) will continue coverage through the STAR Medicaid Managed Care plan of their choice from age 21 through the month of their 26th birthday.

STAR Health provides a full-range of Medicaid covered medical and behavioral health services for children in DFPS conservatorship and young adults in DFPS paid placements. Children taken into state conservatorship will be issued one or more of the following forms:

- Medicaid Eligibility Verification (HHSC Form 1027-A)
- Designation of Medical Consenter for non-DFPS Employee (DFPS Form 2085-B)

These forms will include either a Medicaid ID number or the 16-digit DFPS number. Pharmacy staff are allowed to submit prescription claims with the DFPS number immediately, without having to wait for a Medicaid ID to be assigned. After the person receives a Medicaid number, pharmacy staff must submit subsequent claims using the Medicaid ID and not the DFPS number.

1.5.1 Pharmacy Claims Submission

Pharmacy claims using the DFPS number must be submitted with the values identified in Table 6. Refer to the "NCPDP B1 Transaction Billing Request" payer sheet for specific transaction, segment, and field requirements. Download the **VDP Pharmacy Provider Payer Sheets** from the "Downloads" page at txvendordrug.com/about/policy/payer-sheets.

Table 5 - DFPS ID Pharmacy Claims Submission

Field Name	Field Number	Submitted Value
BIN Number	101-A1	610084
Processor Control Number	104-A4	DRTXPROD
Group ID	301-C1	MEDICAID
Cardholder ID	302-C2	16-digit DFPS number
Prior Authorization Type Code	461-EU	8
Prior Authorization Number Submitted	462-EV	1027

1.6 Healthy Texas Women Program

The Healthy Texas Women (HTW) Program consolidates the Texas Women’s Health Program (TWHP) and Expanded Primary Health Care (EPHC) Program. The HTW program expands access to women’s health and family planning services to eligible people, and includes family planning services, related preventive health services that are beneficial to reproductive health, and other preventive health services that positively affect maternal health and future pregnancies.

1.6.1 Pharmacy Claims Submission

Pharmacy claims must be submitted with the values identified in Table 6. Refer to the “NCPDP B1 Transaction Billing Request” payer sheet for specific transaction, segment, and field requirements. Download the **VDP Pharmacy Provider Payer Sheets** from the "Downloads" page at txvendordrug.com/about/policy/payer-sheets.

Table 6 - HTW Program Pharmacy Claims Submission

Field Name	Field Number	Submitted Value
BIN Number	101-A1	610084
Processor Control Number	104-A4	DRTXPROD
Group ID	301-C1	MEDICAID

2 Pharmacy Verification of Eligibility

Pharmacy staff have various sources and methods that may be utilized to verify a person's enrollment status, pharmacy benefits, participation in managed care, and Medicare coverage. Pharmacy staff should verify eligibility with the same processor that will be used to eventually process the claim.

2.1 Real-time Verification

Pharmacy staff using the following real-time eligibility tools will query the VDP Pharmacy Claims System using the person's Medicaid, CHIP, KHC, or CSHCN cardholder ID number. The expanded messaging that is returned will include the most current or last effective eligibility period, prescription limitations, MCO name, and Medicare Part B and D coverage.

2.1.1 Eligibility Verification (E1) Transaction

The National Council for Prescription Drug Programs (NCPDP) Eligibility Verification transaction is submitted from the pharmacy's point-of-sale claim system. Pharmacy providers should contact their software company to discuss E1 submission issues and to ensure the "Additional Message Information" field (526-FQ) is returned for all responses.

Refer to the [System Requirements](#) chapter of the PPPM to learn more about the NCPDP standards for pharmacy claim transactions. Refer to the VDP Pharmacy Provider Payer Sheets for the full list and explanation of the expanded messages. Download the **VDP Pharmacy Provider Payer Sheets** from txvendordrug.com/about/policy/payer-sheets.

2.1.2 VDP Eligibility Verification Portal

The Pharmacy Eligibility Verification Portal (EVP) (txpcra.pharmacy.services.conduent.com/PBMPortal/login.jsp) is a browser-based application used to obtain a person's enrollment status, pharmacy benefits, and managed care participation. All VDP-enrolled pharmacy providers are eligible to create a free account. The EVP is accessible only through the Microsoft® Internet Explorer® browser.

Download the **Pharmacy Eligibility Verification Portal Access Form** from the "Downloads" page at txvendordrug.com/resources/downloads. Refer to the "Pharmacy Verification of Eligibility" section of the [Contact Information](#) chapter of the PPPM for EVP Correspondence.

2.2 Your Texas Benefits Medicaid Card

People eligible for Medicaid should present the Your Texas Benefits Medicaid ID card to obtain Medicaid services when visiting a doctor or dentist office, a clinic, or pharmacy. The card is plastic, like a credit card. New cards are not sent to Medicaid-eligible people each month, and people should keep using the card even if he or she changes MCO.

While prescribing providers may verify eligibility and view available health information at the provider portal, pharmacy staff should use one of the VDP real-time eligibility verification tools to obtain outpatient pharmacy eligibility and prescription benefit information.

Pharmacy staff may call the Your Texas Benefits Provider Help Desk to find enrollment status and the name of the person's MCO. Refer to the "Your Texas Benefits" section of the [Contact Information](#) chapter of the PPPM for about the YourTexasBenefitsCard.com provider portal and help desk.