TEXAS Health and Human Services

Pharmacy Provider Revalidation

Frequently Asked Questions

Updated: Dec. 15, 2020

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 an application, supporting documents, and an application fee. Enrollment forms and instructions are available on the VDP website.

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

   The revalidation process requires a minimum of 30 to 60 business days once HHSC receives your completed application. We may require additional time if further documentation is needed. HHSC recommends you submit your application three months before your enrollment ends.

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

   Yes. HHSC will send a notice about three to four months before your enrollment ends.

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

   Failure to revalidate on time may result in a hold on your eligibility to receive reimbursement or disenrollment from Texas Medicaid. 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 for more information.

7. Is revalidation the same as re-enrollment?

No. Reenrollment occurs when you have been terminated, deactivated, or otherwise removed as a Medicaid provider and seek to reestablish enrollment. Reenrollment is a new enrollment. 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.

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 $595.00 for applications submitted between Jan. 1 and Dec. 31, 2020.
   - The fee is $599.00 for applications submitted between Jan. 1 and Dec. 31, 2021.

2. Do I need to pay the application fee?

   Pharmacies pay the fee for all new enrollment applications, including applications for a new practice location, change in ownership, re-enrollment, and revalidation. The pharmacy must pay the application fee before HHSC processes your application. 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 when submitting your application.
   - Your pharmacy enrolled in Medicare. You must submit proof when submitting your application.
   - You are requesting a hardship exception. Refer to 42 CFR section 424.514. CMS reviews and approves requests on a case-by-case basis.