

Spring 2024 Update Meeting

MMAC Contracts Unit - Topics

- ❖ Current enrollment numbers
- ❖ Contacting the state (MMAC, DSDS, MO HealthNet)
- ❖ Provider Communications Portal (PCP)
- ❖ CDS Managers – Certification
- ❖ Staying Up to Date
- ❖ Different HCBS Forms and where to find them
- ❖ HCBS Change Requests vs. Provider Update Form
- ❖ HCBS Vol. Term form vs Provider Term Request
- ❖ Banking Changes – I know, I Know – it's still an issue
- ❖ HCBS Setting Requirements

HCBS by the Numbers

Currently Enrolled

IHS – 733 (720)↑

CDS – 1307 (1275)↑

ADC – 138 (139)↓

27 – 188 (187)↑

Pending

45

95

4

8





E-mails and Phone Calls

- Leave the following information for a faster response:
 - Your name
 - Your business name
 - Your call back number
 - Your NPI
 - Your question/concern/what you are calling about

- Know your Department:
 - Enrollment & changes to enrollment – **MMAC Provider Contracts**
 - Revalidation – **MMAC Provider Revalidations**
 - Participant issues – **DHSS/Dept. of Senior and Disability Services**
 - Billing Questions – **MO HealthNet**
 - CDS Audits and Reports – **MMAC Provider Review**

Provider Communications Portal (PCP)

The Missouri Medicaid Audit & Compliance (MMAC) created a New Provider Communications Portal. This Portal will be a secure, efficient method for Providers and MMAC to exchange information and records. The new portal provides a ‘One-Stop-Shop’, which will allow Providers to:

- Update and maintain contact information, allowing for multiple contacts.
- Submit a form and supporting documentation for loss or destruction of records.
- Submit any required quarterly/annual reports and audits.
- Submit forms and questions.
- Submit an anonymous complaint or fraud referral.
- Choose to receive targeted emails for specific provider types and retain the communication in the portal.

Provider Communications Portal (PCP)

- Receive text (SMS) messages.
- Securely upload documents electronically versus U.S. mail or attachments to emails.
- Research Frequently Asked Questions.

Register for the portal at: <https://modssmmaclgin.my.site.com/ProviderPortal/s/>

The new portal will allow the MMAC team to send the providers emails and/or text messages advising that they have important program information requiring their attention. **In addition, new capabilities include courtesy reminders, such as when the due date for their five-year revalidation is approaching or when a required quarterly or annual report is due.**

You will need your 9 digit Provider number to register. Enrollments are related per NPI in the system, if you have additional NPIs to be associated with your account, please contact MMAC Contracts Unit with those NPIs and we will “relate” them manually for you.

CDS Certified Manager

208.918.2.3.a – effective 08/28/2020

19 CSR 15-8.400(1)(D) & (E) – effective 2/29/2024

99.7% currently enrolled CDS providers are compliant

Currently working with newly enrolled/pending CDS proposals to meet the requirement.

MMAC will host a testing session every month to the end of 2024 and then will be offered quarterly starting in 2025.

Remaining 2024 dates

October 30 / November 26 / December 19

MMAC – HCBS Provider Forms

- BOS (Business Organization Structure)
- CDS SAC (Service Area Commitment)
- CDS Vendor Profile
- CHANGE REQUEST – HCBS Providers
- EFT – banking
- IHS Provider Profile
- IHS SAC (Service Area Commitment)



<https://mmac.mo.gov/providers/provider-enrollment/home-and-community-based-services/provider-contracts-forms/>



CHANGE REQUEST FORM

As a HCBS provider you are required to submit a Change Request form along with any requested documents/forms listed when you request a change.

(address, telephone, fax, email, days/hours, etc.)

Per 13 CSR 65-2.020(B) - **REQUIRES** MO HealthNet providers to notify MMAC Provider Enrollment Unit (PEU) of any changes to enrollment within 30 days of the effective date, including changes in ownership (CHOW) which must be reported within 30 days of the effective date.


HCBS Change Request VS Provider Update


HCBS Change Request

<https://mmac.mo.gov/wp-content/uploads/sites/11/2022/05/Change-Request-22.pdf>

Provider Update Form

<https://mmac.mo.gov/wp-content/uploads/sites/11/2021/04/Provider-Update-Request.pdf>

 STATE OF MISSOURI DEPARTMENT OF SOCIAL SERVICES MISSOURI MEDICAID AUDIT & COMPLIANCE HOME AND COMMUNITY BASED SERVICES CHANGE REQUEST			
SECTION 1: PROVIDER INFORMATION – COMPLETE ALL APPLICABLE FIELDS IN A LEGIBLE MANNER. Please complete ONE form per provider EIN. THIS IS A REQUIRED SECTION.			
LEGAL AGENCY NAME AS IT APPEARS WITH THE IRS:			
DOING BUSINESS AS NAME (IF APPLICABLE):			
NPI:		SSBG (optional):	
<input type="checkbox"/> CDS	<input type="checkbox"/> In-Home	<input type="checkbox"/> Reassessments	<input type="checkbox"/> Adult Daycare
		<input type="checkbox"/> RCF (Residential Care)	<input type="checkbox"/> ALF (Assisted Living)
EMAIL ADDRESS FOR CONFIRMATION OF CHANGES:			
SECTION 2: MAIN OFFICE CHANGES			
<input type="checkbox"/>	ADDRESS CHANGE – Submit a business license and lease agreement or deed. Explain in Section 8 if not applicable.		
	Main Physical Address address	city	state zip
	Remittance/Mailing Address: address	city	state zip
<input type="checkbox"/>	PHONE NUMBER CHANGES – complete the sections below as applicable:		
	BUSINESS:	DIRECTOR:	
	DESIGNATED MANAGER:	CDS COORDINATOR:	
	RN SUPERVISOR:	EMERGENCY:	
<input type="checkbox"/>	FAX NUMBER CHANGE – list here:		

 MISSOURI DEPARTMENT OF SOCIAL SERVICES MISSOURI MEDICAID AUDIT AND COMPLIANCE UNIT PROVIDER UPDATE REQUEST			
<p>You must submit a separate form for each provider type and/or individual/group. You MUST complete Sections 1 and 2 and the form must be signed. Include the effective date where indicated. Failure to follow these instructions could result in the denial of your request.</p>			
SECTION 1: PROVIDER INFORMATION – complete ONE of the below - for either a group or an individual provider			
INDIVIDUAL PROVIDER:			
LAST NAME		FIRST NAME	
MIDDLE INITIAL	SUFFIX	INDIVIDUAL PROVIDER'S NPI	
GROUP PROVIDER:			
LEGAL BUSINESS NAME AS REGISTERED WITH THE IRS			
DBA (if applicable)			
GROUP PROVIDER'S NPI	TAXONOMY CODE		
SECTION 2: CONTACT PERSON – Authorized person able to discuss the requested change & where notification can be sent.			
NAME	TELEPHONE	E-MAIL ADDRESS	
SECTION 3: MAIN LOCATION CHANGE - List additional locations on a separate sheet. THE FOLLOWING PROVIDERS CANNOT USE EMOMED TO UPDATE ADDRESSES – APRNs, Nurse Midwives, Assistant Physicians, Home & Community Based providers, clinics, and some other organization types. ALL OTHER PROVIDERS PLEASE UTILIZE THE ADDRESS FUNCTION IN EMOMED.			
<input type="checkbox"/> MAIN PHYSICAL LOCATION	<input type="checkbox"/> EDIT	<input type="checkbox"/> DELETE	EFFECTIVE DATE:
ADDRESS CITY STATE ZIP:	COUNTY:		
BUSINESS PHONE NUMBER:	BUSINESS E-MAIL:	GROUP NPI IF APPLICABLE:	BUSINESS FAX NUMBER:
<input type="checkbox"/> REMITTANCE/ PAY TO ADDRESS	<input type="checkbox"/> EDIT	<input type="checkbox"/> DELETE	EFFECTIVE DATE:


HCBS Voluntary Term form VS Provider Termination

HCBS Voluntarily Termination

<https://mmac.mo.gov/wp-content/uploads/sites/11/2022/05/HCBS-Voluntary-Termination-Form-22.pdf>

Voluntary Termination Request

<https://mmac.mo.gov/wp-content/uploads/sites/11/2021/04/Provider-Voluntary-Termination-Request-form-3.2022.pdf>

 STATE OF MISSOURI DEPARTMENT OF SOCIAL SERVICES MISSOURI MEDICAID AUDIT AND COMPLIANCE HCBS VOLUNTARY TERMINATION REQUEST			
SECTION 1: PROVIDER INFORMATION – COMPLETE ALL APPLICABLE FIELDS IN A LEGIBLE MANNER. Please complete ONE form per provider EIN. THIS IS A REQUIRED SECTION.			
LEGAL AGENCY NAME AS IT APPEARS WITH THE IRS:		DOING BUSINESS AS NAME (IF APPLICABLE):	
NPI:		SSBG (optional):	
<input type="checkbox"/> CDS	<input type="checkbox"/> In-Home	<input type="checkbox"/> Reassessments	<input type="checkbox"/> Adult Daycare
		<input type="checkbox"/> RCF (Residential Care)	<input type="checkbox"/> ALF (Assisted Living)
EMAIL ADDRESS FOR CONFIRMATION OF CHANGES:			
SECTION 2: VOLUNTARILY TERMINATE ENROLLMENT – Effective Date Must Be Consistent On All Documents Submitted.			
THE FOLLOWING MUST BE ATTACHED – USE THE CHECKBOXES TO CHECK OF DOCUMENTS:			
<ol style="list-style-type: none"> <input type="checkbox"/> A letter stating that you wish to terminate your enrollment with MO HealthNet – include your NP and effective date in the letter. <input type="checkbox"/> A copy of the letter that you sent to the Department of Health and Senior Services letting them know the effective date you will be terminating your enrollment with MO HealthNet. <input type="checkbox"/> A copy of the letter that was sent to the participants letting them know the effective date you will be terminating your enrollment and that they will need to find a new provider. <input type="checkbox"/> List of Medicaid Participant DCNs serviced by your entity. 			
I WISH TO VOLUNTARILY TERMINATE MY ENROLLMENT WITH MOHEALTHNET EFFECTIVE - LIST MM/DD/YYYY IN BLANK BELOW. DATE MUST BE LISTED ON BLANK TO PROCESS CORRECTLY. EFFECTIVE (MM/DD/YYYY): _____			
Location where records will be stored for 5 years after the date of termination listed above:			
ADDRESS:	CITY:	STATE:	ZIP:
Future contact person name:			



MISSOURI DEPARTMENT OF SOCIAL SERVICES
MISSOURI MEDICAID AUDIT AND COMPLIANCE UNIT
PROVIDER VOLUNTARY TERMINATION REQUEST

A separate form must be submitted for each provider type and/or individual/group. **All Sections MUST be completed** and the form must be signed. Include the effective date where indicated. Failure to follow these instructions could result in the denial of your request.

SECTION I: PROVIDER INFORMATION – Fill in applicable fields with provider's current information.			
FOR INDIVIDUAL'S ONLY: LAST NAME		FIRST NAME	MIDDLE INITIAL
FOR AGENCIES ONLY: PROVIDER NAME		DBA (if applicable)	
NATIONAL PROVIDER IDENTIFIER (NPI)		TAXONOMY CODE	
SECTION II: CONTACT PERSON – Person that can discuss the requested termination and where notification can be sent.			
NAME	TELEPHONE	E-MAIL ADDRESS	
SECTION III: CHANGE REQUEST – Please provide an updated address.			
<input type="checkbox"/> CURRENT ADDRESS		<input type="checkbox"/> EDIT	EFFECTIVE: / /
ADDRESS	CITY	STATE	ZIP CODE
<input type="checkbox"/> VOLUNTARILY TERMINATE MEDICAID ENROLLMENT EFFECTIVE: / /			
SECTION IV: REASON FOR VOLUNTARY TERMINATION REQUEST/COMMENTS			
SECTION V: FUTURE RECORD RETENTION INFORMATION – RECORDS MUST BE STORED FOR 5 YEARS AFTER THE TERMINATION DATE ABOVE (7 YEARS FOR NURSING HOME, CSTAR AND COMMUNITY PSYCHIATRIC REHABILITATION PROGRAMS):			

Personnel Change

SECTION 4: STAFF CHANGES – A CURRENT FCSR MUST BE SUBMITTED			
<input type="checkbox"/> Update contact person for a satellite office - a current FCSR is required			
Name:			
Date of birth:	SSN:	Date of hire:	
<input type="checkbox"/> DIRECTOR NAME:		<input type="checkbox"/> CDS COORDINATOR NAME:	
Date of birth:	SSN:	Date of birth:	SSN:
Office address:		Office address:	
Date of Hire:		Date of Hire:	
<input type="checkbox"/> IHS DESIGNATED MANAGER NAME:		<input type="checkbox"/> IHS RN SUPERVISOR NAME:	
Date of birth:	SSN:	Date of birth:	SSN:
Office address:		Office address:	
Date of Hire:		Date of Hire:	
THE FOLLOWING MUST BE ATTACHED: <ul style="list-style-type: none"> - Copy of licensure or degree - Copy of Provider Certification Training - Copy of Resume 		THE FOLLOWING MUST BE ATTACHED: <ul style="list-style-type: none"> - Copy of licensure - Copy of employment application 	

- If adding a new staff member – please notify MMAC on the change request if to prior person is leaving
- Include updated email and phone if different
- MMAC only makes the changes indicated

Updating Contact Numbers

<input type="checkbox"/>	PHONE NUMBER CHANGES – <u>complete the sections below as applicable:</u>	
	BUSINESS:	DIRECTOR:
	DESIGNATED MANAGER:	CDS COORDINATOR:
	RN SUPERVISOR:	EMERGENCY:
<input type="checkbox"/>	FAX NUMBER CHANGE – list here:	
<input type="checkbox"/>	EMAIL ADDRESS CHANGE – list here:	

When updating phone numbers – please put the phone number you want updated in the appropriate box (not the name of the person)



Changing Banking Accounts

- Using the current EFT on MMAC website
- 3 Step Verification: 1. review for accuracy 2. send verification email to the email on enrollment 3. verification made by submitting provider – THEN updated into the system

DO NOT close the current account until a deposit has been made into the new account or your payments will be delayed

Sometimes banking changes are kicked back for one reason or another; that is why we ask that you NOT close the old account until a deposit has been made into the new one. This is also why we state to keep your address up to date (paper checks)

HCBS Settings Requirement

- To ensure that individuals receive Medicaid HCBS in settings that have access to benefits of community living and are able to receive services in the most integrated setting
- To improve the quality of services for individuals receiving HCBS.
- This is a requirement from CMS – it applies to all HCBS, however in MO In Home and CDS are just that –services in the home – only our heightened scrutiny providers such as Adult Day Cares are required to attend the annual training and submit forms yearly
- Annual Trainings are held in November and forms are due by year end (December 31)



THANK YOU

Contact Info:

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MMAC Contracts Unit

Please send emails to

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