Spring 2024 Update Meeting

MMAC Contracts Unit - Topics

- Current enrollment numbers
- Contacting the state (MMAC, DSDS, MO HealthNet)
- 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

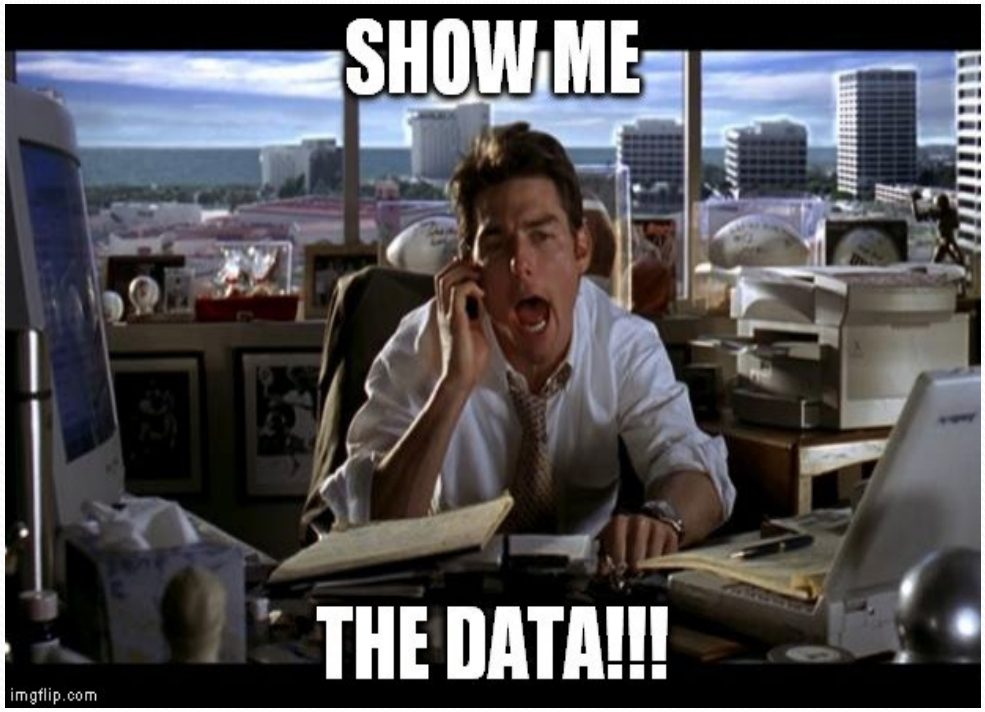
Currently Enrolled

IHS – 720 (704)⬆

CDS – 1275 (1247)⬆

ADC – 139 (137)⬆

27 – 187 (218)⬇



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

CDS Certified Manager

208.918.2.3.a – effective 08/28/2020

The department of health and senior services shall promulgate by rule a consumer-directed services division provider certification manager course;

19 CSR 15-8.400 – effective 2/29/2024

(D) Designate to MMAC the manager who will be responsible for the vendor's day-to-day operation…

(E) Implement a quality assurance and supervision process that ensures program compliance and accuracy of records, including but not limited to—

1. **CDS managers** shall be required to successfully **complete (or have completed) the CDS certified manager orientation and test offered** (quarterly or as needed) by MMAC at no charge. Completion of the test for all new managers is required within six (6) months of hire;

CDS Certified Manager

First round testing complete of CDS providers currently enrolled *up to February* 2024.

Results from first round:

- 35% of all enrolled CDS providers
- March and some April enrolled providers will be added to second round testing

Second Testing – will be last two weeks in May (21 & 23 with alternate dates of 29 & 30). Again dates will be based upon NPI

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.

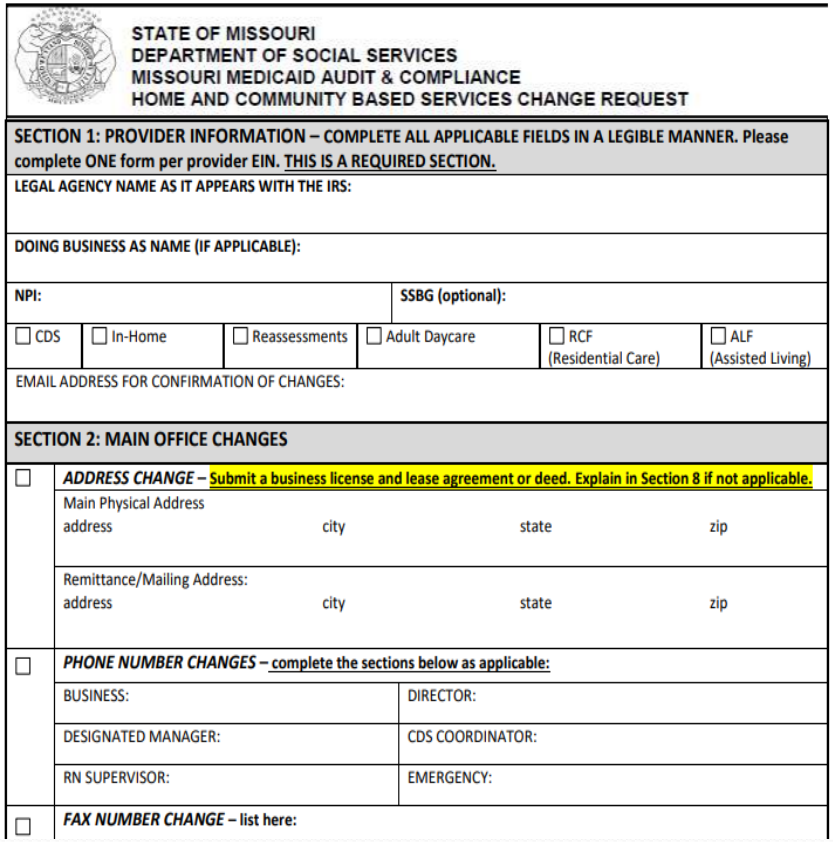
(address, telephone, fax, email, days/hours, etc.)

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



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):

☐ CDS | ☐ In-Home | ☐ Reassessments | ☐ Adult Daycare | ☐ RCF (Residential Care) | ☐ ALF (Assisted Living)

EMAIL ADDRESS FOR CONFIRMATION OF CHANGES:

SECTION 2: MAIN OFFICE CHANGES

☐ ***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

☐ ***PHONE NUMBER CHANGES*** – complete the sections below as applicable:

BUSINESS: | DIRECTOR:

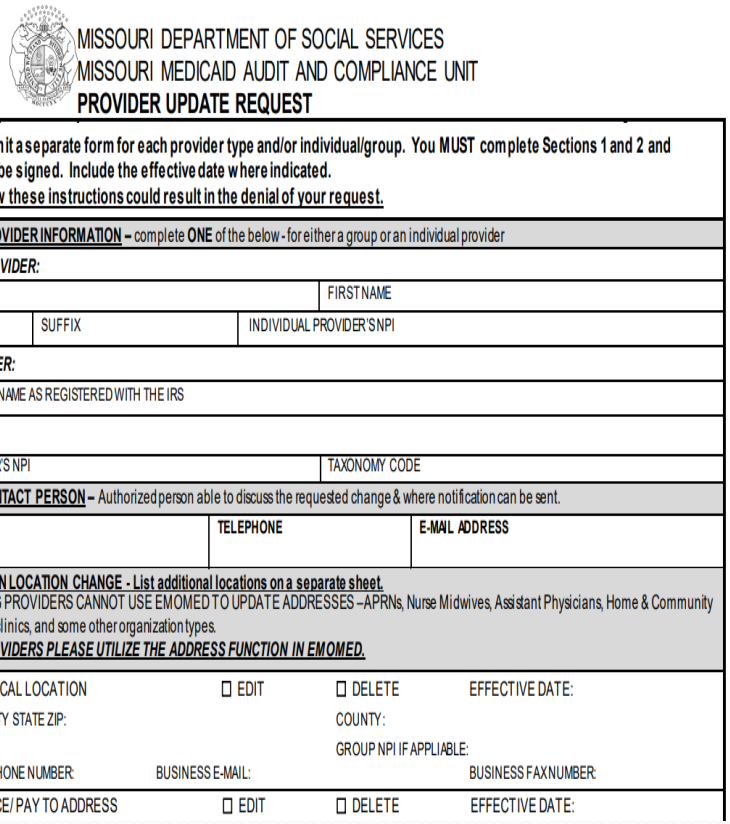
DESIGNATED MANAGER: | CDS COORDINATOR:

RN SUPERVISOR: | EMERGENCY:

☐ ***FAX NUMBER CHANGE*** – list here:

Provider Update Form

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



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

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.

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.

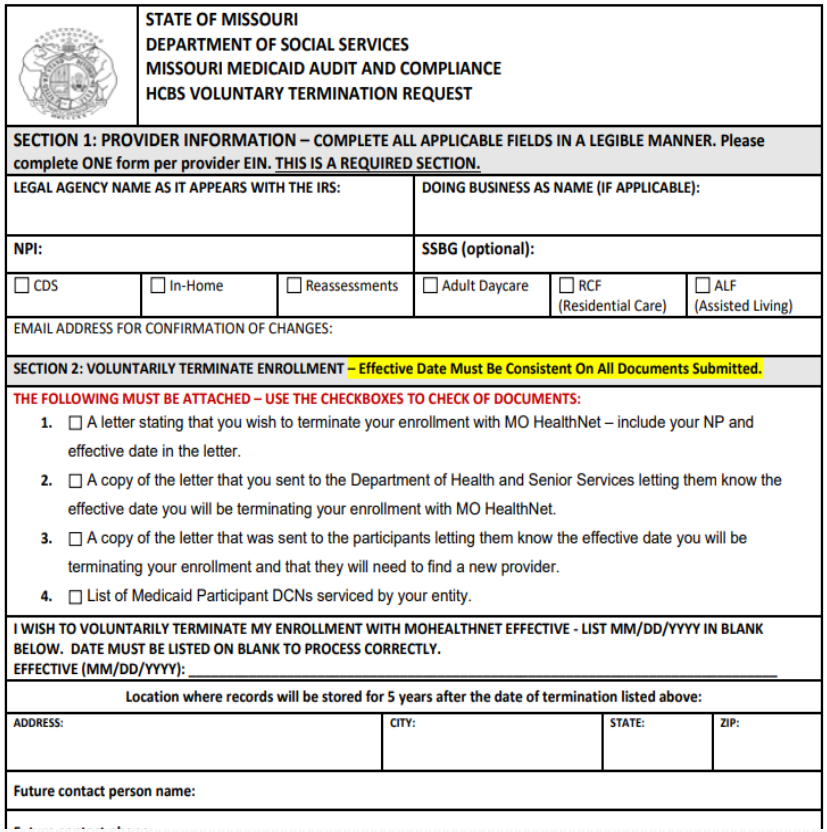
☐ MAIN PHYSICAL LOCATION ☐ EDIT ☐ DELETE EFFECTIVE DATE:
ADDRESS CITY STATE ZIP: COUNTY:
GROUP NPI IF APPLIABLE:
BUSINESS PHONE NUMBER: BUSINESS E-MAIL: BUSINESS FAX NUMBER:

☐ REMITTANCE/ PAY TO ADDRESS ☐ EDIT ☐ 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



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):

☐ CDS ☐ In-Home ☐ Reassessments ☐ Adult Daycare ☐ RCF (Residential Care) ☐ 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:

1. ☐ A letter stating that you wish to terminate your enrollment with MO HealthNet – include your NP and effective date in the letter.
2. ☐ 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.
3. ☐ 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.
4. ☐ 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): _____

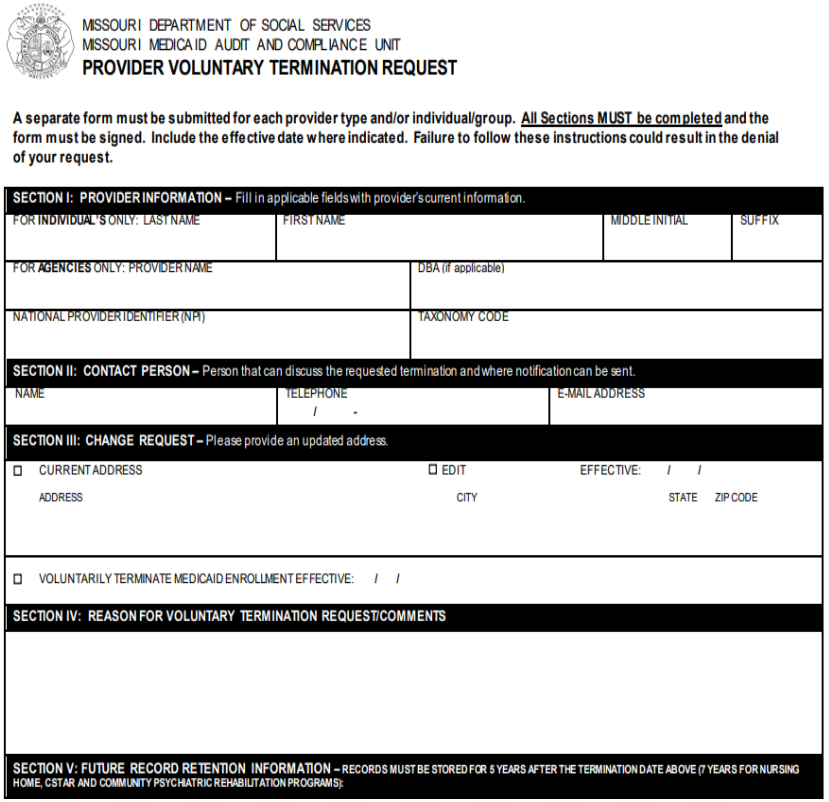
Location where records will be stored for 5 years after the date of termination listed above:

ADDRESS:	CITY:	STATE:	ZIP:

Future contact person name:

Voluntary Termination Request

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



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 **INDIVIDUALS** ONLY: LAST NAME	FIRST NAME	MIDDLE INITIAL	SUFFIX
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.

☐ CURRENT ADDRESS ☐ EDIT EFFECTIVE: / /

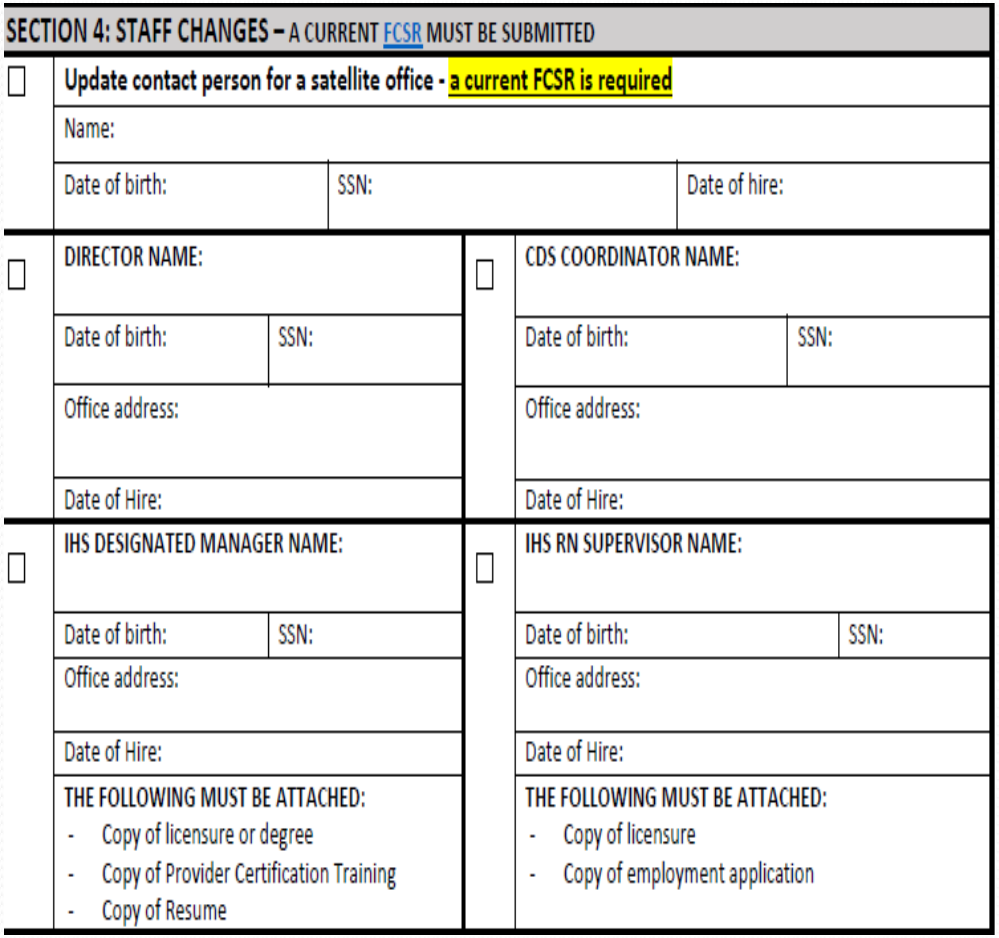
ADDRESS CITY STATE ZIP CODE

☐ 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

☐ **Update contact person for a satellite office - a current FCSR is required**

Name:

Date of birth: | SSN: | Date of hire:

☐ **DIRECTOR NAME:**

Date of birth: | SSN:

Office address:

Date of Hire:

☐ **CDS COORDINATOR NAME:**

Date of birth: | SSN:

Office address:

Date of Hire:

☐ **IHS DESIGNATED MANAGER NAME:**

Date of birth: | SSN:

Office address:

Date of Hire:

THE FOLLOWING MUST BE ATTACHED:
- Copy of licensure or degree
- Copy of Provider Certification Training
- Copy of Resume

☐ **IHS RN SUPERVISOR NAME:**

Date of birth: | SSN:

Office address:

Date of Hire:

THE FOLLOWING MUST BE ATTACHED:
- 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

☐	***PHONE NUMBER CHANGES –*** complete the sections below as applicable:	
	BUSINESS:	DIRECTOR:
	DESIGNATED MANAGER:	CDS COORDINATOR:
	RN SUPERVISOR:	EMERGENCY:
☐	***FAX NUMBER CHANGE*** – list here:	
☐	***EMAIL ADDRESS CHANGE*** – list below. Use section 6 or another sheet to report more than 1 e-mail change:	

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:

Cindy Werdehausen

MMAC Contracts Unit

Please send emails to

mmac.ihscontracts@dss.mo.gov