



Rules of
Department of Social Services
Division 65—Missouri Medicaid Audit and Compliance
Chapter 2—Medicaid

Title	Page
13 CSR 65-2.010 Definitions	3
13 CSR 65-2.020 Provider Enrollment and Application	5
13 CSR 65-2.030 Denial or Limitations of Applying Provider	9



**Title 13—DEPARTMENT OF
SOCIAL SERVICES**

**Division 65—Missouri Medicaid Audit
and Compliance
Chapter 2—Medicaid**

13 CSR 65-2.010 Definitions

PURPOSE: This rule implements federal regulatory requirements promulgated by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services at 76 Fed. Reg. 5862 (February 2, 2011), 42 CFR Parts 455 and 457, defining the terms used in the rules of the Missouri Medicaid Audit and Compliance Unit.

- (1) Affiliates means persons having an overt, covert, or conspiratorial relationship so that any one (1) of them directly or indirectly controls or has the power to control another.
- (2) Agent means any person who has been delegated the authority to obligate or act on behalf of a provider.
- (3) Application shall include:
- (A) Enrollment application to become a MO HealthNet Program provider;
 - (B) Revalidation application to remain a MO HealthNet Program provider;
 - (C) New practice location application;
 - (D) Provider direct deposit application;
 - (E) Change of ownership application;
 - (F) Hardship waiver request; or
 - (G) Other information Missouri Medicaid Audit and Compliance (MMAC) needs, under applicable federal or state laws and regulations as they pertain to the Medicaid program, in order to enroll a MO HealthNet Program provider.
- (4) Application fee means a fee required to be paid by a MO HealthNet Program institutional provider at the time of—
- (A) Initial application;
 - (B) Revalidation application;
 - (C) Change of ownership application; or
 - (D) New practice location application.
- (5) Applying provider means any person submitting an application as defined in section (3) above.
- (6) Approve/approval as to a billing provider means the billing provider has been determined to be eligible under Medicaid rules and regulations to receive a Medicaid billing number and be granted Medicaid billing privileges.
- (7) Approve/approval as to a performing provider means the performing provider has been determined to be eligible under Medicaid rules and regulations to receive a non-billing Medicaid number.
- (8) Best interests of the MO HealthNet Program shall include consideration of the following factors:
- (A) Ensuring reasonable access to MO HealthNet Program services;
 - (B) Promoting health, safety, and welfare of participants;
 - (C) The provider's history of compliance with applicable rules and regulations related to the MO HealthNet Program; and
 - (D) Any other factors related to MO HealthNet Program integrity.
- (9) Billing provider means a provider or supplier who is authorized to bill the MO HealthNet Program for items or services provided to Medicaid participants. Billing provider includes providers who are authorized to bill Medicaid for items or services provided by performing providers.
- (10) Closed-end provider agreement means an agreement which is for a specific period of time not to exceed twenty-four (24) months and which must be renewed in order for the provider to continue to participate in the Missouri Medicaid Program.
- (11) Conviction or convicted means that—
- (A) A judgment of conviction has been entered by a federal, state, or local court, regardless of whether an appeal from that judgment is pending;
 - (B) A person has pled guilty to a criminal offense; or
 - (C) A person is serving any period of probation or parole, regardless of any suspended imposition of sentence or suspended execution of sentence resulting from that offense.
- (12) Deactivate means that the provider's participation in the MO HealthNet program is stopped.
- (13) Deny/denial means the applying provider has been determined to be ineligible under Medicaid rules and regulations to participate in the MO HealthNet program.
- (14) Department means the Department of Social Services or its designated divisions or units.
- (15) Enroll/enrollment means the process that MMAC uses to establish eligibility to participate as a provider in the MO HealthNet program. The process includes:
- (A) Identification of a provider and any owners;
 - (B) Validation of the provider's qualifications to meet program requirements;
 - (C) Screening the provider and owners through all required federal and state databases;
 - (D) Identification and confirmation of the provider's practice location(s) and owner(s); and
 - (E) Granting the provider a MO HealthNet number.
- (16) Enrollment application means a MMAC approved paper enrollment application or a MMAC approved electronic enrollment process.
- (17) Exclusion from participation in a federal health care program (e.g., Medicare and Medicaid) is a penalty imposed on a provider by the Office of Inspector General (OIG) under section 1128 or 1128A of the Social Security Act. States may also exclude providers from their Medicaid Programs under state law or pursuant to 42 CFR section 1002.2.
- (18) Federal health care program means a program as defined in section 1128B(f) of the Social Security Act.
- (19) Fiscal agent means an organization under contract to the state of Missouri for providing services related to the administration of the MO HealthNet Program.
- (20) Hardship means a financial condition in which paying the application fee would impose a significant financial burden on the provider, and the provider is otherwise eligible to be a MO HealthNet Program provider. Other factors which may indicate that a hardship exists include:
- (A) Considerable bad debt expenses incurred by the provider;
 - (B) Considerable amount of charity care/financial assistance furnished to patients;
 - (C) Presence of substantive partnerships (whereby clinical, financial integration are present) with those who furnish medical care to a disproportionately low-income population;
 - (D) Whether an institutional provider receives considerable amounts of funding through disproportionate share hospital payments; or
 - (E) Whether the provider is enrolling in a geographic area that is a presidentially declared disaster area under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. sections 5121-5206 (Stafford Act).
- (21) Hardship waiver request means a request submitted to MMAC (defined below) along



with the provider application requesting that the application fee be waived due to hardship, detailing the hardship, and providing any documentation in support of the hardship waiver request.

(22) Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

(23) Limited provider agreement means an agreement with an applying provider which has been accepted as a MO HealthNet Program provider by MMAC (defined below) conditional upon the applying provider performing services, delivering supplies, or otherwise participating in the program only in adherence to, or subject to, specially set out conditions agreed to by the applying provider prior to enrollment.

(24) Managed care entity means managed care organizations (MCOs), pre-paid inpatient health plans (PIHPs), pre-paid ambulatory health plans (PAHPs), primary care case management (PCCMs), and health improvement organizations (HIOs) or any similar managed care program type created by the state Medicaid agency.

(25) Managing employee means an owner, member, partner, director, general manager, business manager, administrator, school district superintendent, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of the provider, either under contract or through some other arrangement, whether or not the individual is a W-2 employee of the provider.

(26) Medicaid agency or the agency means the single state agency administering or supervising the administration of the state Medicaid plan.

(27) Missouri Medicaid Audit and Compliance Unit (MMAC) means the unit within the Department of Social Services that is responsible for program integrity and compliance in the Medicaid Title XIX, CHIP Title XXI, and Waiver Programs in Missouri, which includes the enrollment and auditing of MO HealthNet providers and Medicaid participants through the lock-in program. MMAC is charged with the responsibility of detecting, investigating, and preventing fraud, waste, and abuse of the Missouri Medicaid Title XIX, CHIP Title XXI, and Waiver Programs.

(28) Medical assistance benefits means those benefits authorized to be provided by Chapter 208, RSMo.

(29) MO HealthNet Program means programs operated pursuant to Title XIX of the Social Security Act, Title XXI of the Social Security Act, and/or waiver programs authorized by the United States Department of Health and Human Services.

(30) MO HealthNet means the division within the department, pursuant to sections 208.001 and 208.201, RSMo, that administers the Medicaid Title XIX, CHIP Title XXI, and waiver programs, approves claims from MO HealthNet providers for services or merchandise provided to eligible Medicaid participants, and authorizes and disburses payment for those services or merchandise accordingly.

(31) The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use NPIs in administrative and financial transactions adopted under HIPAA.

(32) Network Provider means any provider, group of providers, or entity that has a network provider agreement with a MCO, or a subcontractor, and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the state's contract with an MCO. A network provider is not a subcontractor by virtue of the network provider agreement.

(33) Open-end provider agreement means an agreement that has no specific termination date and continues in force as long as it is agreeable to both the state Medicaid agency and the enrolled provider.

(34) Organizational provider is a non-corporate provider. Individual physicians or other individually licensed practitioners are not institutional providers. Organizational provider includes, but is not limited to:

(A) Ambulance service suppliers, health clinics, hospitals, pharmacies, and skilled nursing facilities;

(B) Other organizational entities that bill the MO HealthNet Program on a fee-for-service basis, such as personal care agencies, nonemergency transportation providers, residential care facilities, adult day care facilities, assisted living facilities, residential treatment centers, providers billing under the Consumer Directed Services Program or

entities established under sections 205.968-205.973, RSMo; and

(C) Any other types of non-corporate MO HealthNet Program providers consistent with the state plan, the Waiver Program, and CHIP Title XXI.

(35) Other disclosing entity means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII, or XX of the Act. This includes:

(A) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization (meaning all MCOs) that participates in Medicare (Title XVIII);

(B) Any Medicare intermediary or carrier; and

(C) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX of the Act.

(36) Participant means a person who is eligible to receive benefits allocated through the department as part of the MO HealthNet Program.

(37) Participation means the ability and authority to provide services or merchandise to eligible MO HealthNet participants.

(38) Performing provider means a provider or supplier who provides items or services to Medicaid participants, but who does not directly bill or receive payment from the MO HealthNet Program. Performing provider can also include referring, ordering, prescribing, and/or attending physicians, and non-physician practitioners.

(39) Person means any corporeal person or individual; or any legal or commercial entity, including but not limited to, any partnership, corporation, not-for-profit, professional corporation, business trust, estate, trust, limited liability company, association, joint venture, governmental agency, or public corporation.

(40) Person with an ownership or control interest, as defined in sections 1124 and 1124A(a) of the Social Security Act, means a person or corporation that—

(A) Has an ownership interest totaling five percent (5%) or more in a disclosing entity;

(B) Has an indirect ownership interest equal to five percent (5%) or more in a disclosing entity;



(C) Has a combination of direct and indirect ownership interests equal to five percent (5%) or more in a disclosing entity;

(D) Owns an interest of five percent (5%) or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least five percent (5%) of the value of the property or assets of the disclosing entity;

(E) Is an officer or director of a disclosing entity that is organized as a corporation;

(F) Is a partner in a disclosing entity that is organized as a partnership; or

(G) Is a managing employee.

(41) Practitioner means a physician or other individual licensed under state law to practice his or her profession.

(42) Provider means billing and performing providers and includes any person that enters into a contract or provider agreement with MMAC for the purpose of providing items or services to Missouri Medicaid participants. Provider includes ordering, referring, prescribing, and/or attending physicians, and non-physician practitioners.

(43) Provider agreement means an agreement with MMAC which authorizes a provider to furnish items or services to eligible Missouri Medicaid participants.

(44) Provider application means the MMAC approved application and supplemental forms required to be submitted for the purpose of becoming a MO HealthNet Program provider, containing information and documentation requested by MMAC.

(45) Provider direct deposit means a form specified by MMAC and submitted by a provider of Medicaid Title XIX, CHIP Title XXI, or Waiver Program services for the purpose of having Missouri Medicaid checks automatically deposited to an authorized bank account.

(46) Reject/rejected means that the provider's enrollment application was not approved due to incomplete or incorrect information, failure to submit an application fee, or the applying provider is not eligible to participate in the MO HealthNet Program.

(47) Revalidation means the requirement that all existing providers must go through an application process to verify their enrollment information is current, and they are still eligible to participate in the MO HealthNet Program.

(48) Revalidation application means an approved MMAC revalidation application and

supplemental forms which are required to be submitted by all existing providers, containing all information and documentation requested by MMAC under applicable federal or state laws and regulations, and submitted at the time revalidation is required pursuant to this rule.

(49) Site visit may include any or all of the following:

(A) Physical visit to, and inspection of, the premises of the provider or a beneficiary's home if the provider has no central operational facility;

(B) Obtaining photographs of the provider or the provider's business for inclusion in the provider's enrollment file;

(C) Full documentation of observations made at the provider's premises including such facts as:

1. The facility was vacant and free of all furniture;

2. A notice of eviction or similar documentation is posted at the facility; and

3. The premises are not occupied by the provider, but by another person;

(D) A written report of the findings regarding each site visit;

(E) Verification that the facility is operational, open for business, and staff is present;

(F) Verification that customers are present at the facility where appropriate for the provider type;

(G) Acceptance of attestation with documentation when deemed appropriate by MMAC and consistent with applicable federal or state laws and regulations; or

(H) Acceptance of proof of a recent site visit under the Medicare program or other state Medicaid program when deemed appropriate by MMAC and consistent with applicable federal or state laws and regulations.

(50) State plan means a document completed by the state of Missouri to tell the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) how the state will administer the MO HealthNet Program according to federal laws and regulations.

(51) Subcontractor means—

(A) An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or

(B) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

(52) Supplier means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

(53) Suspension from participation means a provider is not authorized to provide MO HealthNet Program services for a specified or indefinite period of time.

(54) Suspension of payments means withholding of MO HealthNet Program payments otherwise due to a provider for a specified or indefinite period of time.

(55) Termination means the department's discontinuation of a provider's participation in the MO HealthNet program.

(56) Voluntary termination means that a provider submits written confirmation to MMAC of its decision to discontinue participation in the MO HealthNet Program.

(57) Waiver program means programs authorized in section 1915 of the Social Security Act (or other waiver programs authorized by federal law).

(58) Written notice means a notice to the address of the provider as listed in MMAC's system, in writing, transmitted via the US mail, other public or private service for the delivery of correspondence, packages, or other things, facsimile, e-mail, or any other method/mode of transmittal that is deemed by MMAC to be an efficient, cost-effective, verifiable, and reliable method/mode of communication with the provider or applying provider.

AUTHORITY: sections 208.159 and 660.017, RSMo 2016. Original rule filed Dec. 12, 2013, effective July 30, 2014. Amended: Filed Aug. 20, 2021, effective March 30, 2022.*

**Original authority: 208.159, RSMo 1979, and 660.017, RSMo 1993, amended 1995.*

13 CSR 65-2.020 Provider Enrollment and Application

PURPOSE: This rule implements federal regulatory requirements promulgated by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services at 76 Fed. Reg. 5862 (February 2, 2011), 42 CFR Parts 455 and 457, establishing the basis on which providers under the MO HealthNet Program may be approved or denied as a new provider and/or as a revalidating provider, establishing the



basis on which a new practice location may be approved or denied, establishing a revalidation requirement for all providers and establishing application and periodic screening requirements.

PUBLISHER'S NOTE: The secretary of state has determined that publication of the entire text of the material that is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Enrollment.

(A) All persons are required to enroll with MMAC as a billing or performing provider in the MO HealthNet Program if the services or items they provide will be billed to the MO HealthNet Program.

(B) For any person to receive payment from the MO HealthNet Program for items or services other than out-of-state emergency services, the billing providers and the performing providers of such items or services must be enrolled providers in the MO HealthNet Program on the date the items or services are provided unless applicable rules or manuals permit enrollment as of an earlier date, up to a maximum of three hundred sixty-five (365) days prior to the actual enrollment date.

(C) All claims for payment for items and services that were ordered, prescribed, or referred must contain the National Provider Identifier (NPI) of the provider who ordered, prescribed, or referred such items or services.

(D) All persons enrolled as MO HealthNet providers shall abide by the policies and procedures set forth in the MO HealthNet provider manual(s) applicable to the provider's provider type(s). The MO HealthNet provider manuals are incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109 and available at <http://manuals.momed.com/manuals/>, August 20, 2021. This rule does not incorporate any subsequent amendments or additions. A MO HealthNet provider's breach of any MO HealthNet provider manual may result in imposition of sanctions, including but not limited to termination.

(2) Applications.

(A) All applying providers shall have a valid email address and shall submit a MMAC-approved application and any supplemental forms, information, and documentation required by MMAC for the appropriate provider type for which the person is applying.

(B) All information and documentation requested in the application and supplemental forms must be provided to MMAC prior to the application being approved.

(C) Specific application instructions are modified as necessary for efficient and effective administration of the MO HealthNet Program as required by federal or state laws and regulations. Providers applying on or after the promulgation of this rule should refer to the appropriate MMAC application filing instructions, which are incorporated by reference and made a part of this rule as published by the Department of Social Services, Missouri Medicaid Audit and Compliance Unit, 205 Jefferson Street, Second Floor, Jefferson City, MO 65109, at its website mmac.mo.gov, August 20, 2021. This rule does not incorporate any subsequent amendments or additions.

(D) The application shall include all information required in the mandatory disclosures pursuant to section (3) of this rule. Upon submission of any application(s), supplemental form(s), information and documentation requested in the application(s) and supplemental form(s), MMAC may, at its discretion, request additional or supplemental information and documentation from the applying provider prior to considering the application and/or conducting screening pursuant to this rule in order to clarify any information previously submitted and to verify that the provider meets all applicable requirements of state or federal laws and regulations.

(3) All providers, fiscal agents, managed care entities, and persons with an ownership or control interest in the provider are required to disclose as follows:

(A) The following disclosures are mandatory:

1. The name and address of the applying provider and any person(s) with ownership in the provider. The address must include the provider's primary business address, each additional practice location(s), and any corresponding PO Box addresses;

2. Dates of birth and Social Security numbers (in the case of a corporeal person);

3. Other tax identification number(s) of any person with ownership in the provider or in any subcontractor in which the provider has a five percent (5%) or more interest;

4. Whether any person with ownership in the applying provider is related to another person with ownership in the provider as a spouse, parent, child, or sibling;

5. Whether any person with ownership in any subcontractor in which the provider has a five percent (5%) or more interest is related to another person with ownership in the provider as a spouse, parent, child, or sibling;

6. The name of any other provider(s) in which an owner of the applying or enrolled provider has ownership; and

7. The name, address, date of birth, and Social Security number of any managing employee of the provider;

(B) Disclosures from any provider are due at the following times, and must be updated within thirty (30) days of any changes in information required to be disclosed:

1. Upon initial enrollment, reenrollment, or revalidation; and

2. Upon request of MMAC;

(C) Disclosures from fiscal agents are due at the following times:

1. Upon the fiscal agent submitting a proposal;

2. Upon request of MMAC;

3. Ninety (90) days prior to renewal or extension of a contract; and

4. Within thirty (30) days after any change in ownership of the fiscal agent;

(D) Disclosures from managed care entities (managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans, and health insuring organizations), except primary care case management programs, are due at the following times:

1. Upon the managed care entity submitting a proposal;

2. Upon request of MMAC;

3. Ninety (90) days prior to renewal or extension of the contract; and

4. Within thirty (30) days after any change in ownership;

(E) Disclosures from Primary Care Case Management Programs (PCCM). PCCMs will comply with disclosure requirements under subsection (B) of this section;

(F) All disclosures must be provided to MMAC. Disclosures not made to MMAC will be deemed non-disclosed and not in compliance with this section; and

(G) Administrative action(s) for failure to provide required disclosures.

1. Any person's failure to provide, or timely provide, disclosures pursuant to this section may result in deactivation, denial, rejection, suspension, or termination of the provider's participation in the MO HealthNet program. If the failure is inadvertent or merely technical, MMAC may choose not to



impose administrative actions if, after notice, the provider promptly corrects the failure.

(4) Provider Revalidation.

(A) All providers shall revalidate their enrollment with the MO HealthNet Division at least every five (5) calendar years from the effective date of the provider's most recently executed provider agreement, in order to remain a MO HealthNet provider. For example, a provider whose initial or revalidated provider agreement was effective on March 1, 2020, is required to revalidate their enrollment no later than March 1, 2025. MMAC may request that the provider revalidate on an off-cycle revalidation period.

(B) The MMAC-approved revalidation application, supplemental forms, information, and documentation requested by MMAC, along with the application fee and/or hardship waiver request, if applicable, shall be submitted no later than one hundred twenty (120) days prior to the expiration of the effective provider agreement.

(C) Revalidating providers must comply with the requirements of this rule and will be subject to the screening process noted in this rule in order to have their applications for revalidation approved.

(5) Application Fee.

(A) An application fee, hardship waiver request, and/or an exemption reason provided in this rule must accompany every organizational provider's application.

(B) The application fee must be in the form of a cashier's check, money order, or an electronic payment acceptable to MMAC and for the correct application fee amount in effect as of the date of receipt by MMAC.

(C) Failure to submit the application fee in an acceptable form and/or for the correct amount may result in the return of the fee to the provider and rejection of the application.

(D) Applying and revalidating providers must submit an application fee, determined as follows:

1. As of the effective date of this rule for calendar year 2021, five hundred ninety-nine dollars (\$599.00); and

2. For calendar year 2022 and subsequent years—

A. The amount of the application fee shall be the amount for the preceding year adjusted by the percentage change in the consumer price index for all urban consumers for the twelve- (12-) month period ending with June of the previous year as published by the Bureau of Labor Statistics of the United States Department of Labor.

(E) If MMAC determines that a person is an organizational provider, that person is

required to pay the application fee.

(F) Exemptions from Application Fee. MMAC may waive the application fee under the following conditions:

1. Providers who are enrolled in and paid the application fee required by CMS for Medicare or another state's Title XIX or Title XXI program within two (2) years of the date the application to enroll as a MO HealthNet Provider shall be exempt from paying an application fee;

2. MMAC, in consultation with other state of Missouri departments, divisions, and units, determines that imposition of the application fee would impede Missouri Medicaid participants' access to care;

3. A provider is submitting a provider application as a result of a national or state public health emergency situation as lawfully declared by a federal or state authority; and

4. The provider is owned and operated by the state of Missouri or an agency of the state of Missouri.

(G) Providers seeking an exemption from the application fee are responsible for notifying MMAC, in writing, that they qualify for exemption and for providing proof of such qualification.

(6) Hardship Waiver Request.

(A) Providers can request a hardship waiver of the application fee from the Centers for Medicare and Medicaid (CMS) when submitting their initial enrollment application or a revalidation application, but the request must be received by MMAC before the application will be processed by MMAC. A hardship waiver request will not be considered if it is received by MMAC after MMAC approves the application or revalidation. If CMS approves the hardship waiver, MMAC will refund the application fee to the provider.

(B) A provider that requests a hardship waiver must submit a letter and supporting documentation that describes the hardship and why the hardship justifies an exception, including providing comprehensive documentation (which may include, but is not limited to, historical cost reports, recent financial statements such as balance sheets and income statements, cash flow statements, or tax returns).

(C) Factors that may suggest a hardship exception is appropriate include but are not limited to the following:

1. Considerable bad debt expenses;

2. Significant amount of charity care/financial assistance furnished to patients;

3. Presence of substantive partnerships with those who furnish care to a disproportionately low-income population;

4. Whether an institutional provider receives considerable amounts of funding through disproportionate share hospital payments; or

5. Whether the provider is enrolling in a geographic area that is a presidentially declared disaster area under the Robert T. Stafford Disaster Relief and Emergency Assistance Act.

(D) Upon receipt of a hardship waiver request with an application, MMAC will send the request and all accompanying documentation to CMS. CMS will determine if the request should be approved. CMS will communicate its decision to the institutional provider and MMAC via letter.

(7) Appeal of the Denial of a Hardship Waiver Request. A provider may file a written reconsideration request with CMS within sixty (60) calendar days from the date of the notice of initial determination. The request must be signed by the individual provider, a legal representative, or any authorized official within the entity. The procedures for submitting an appeal will be provided on the denial letter from CMS.

(8) MMAC shall use the application fee to offset the costs associated with the provider screening program in its entirety. This includes but is not limited to the following:

(A) Implementation and augmentation of MMAC's provider enrollment system; and

(B) Any other administrative costs related to the provider screening program, which include costs associated with processing fingerprints and conducting criminal background checks. The application fee does not cover the cost associated with capturing fingerprints and a provider may be charged additional costs for this purpose in addition to the application fee.

(9) Refund of the Application Fee.

(A) If an institutional provider is granted a hardship exception pursuant to this rule or if the application is rejected because it was not properly signed or is missing other information required to be provided on the application itself, and an application fee was included with the application and the hardship waiver request, the application fee shall be returned to the applying provider.

(B) Once the screening process has begun, regardless whether the application goes through part or all of the screening process, the application fee is non-refundable.

(10) Screening.

(A) The screening requirements contained in this section apply to all applying providers



and to all persons disclosed, or required to be disclosed, in the application.

(B) MMAC shall conduct pre-enrollment screening and post-enrollment monthly screenings. Screenings may include the following:

1. Screening pursuant to 42 CFR sections 455.410(a) and (b), 42 CFR 455.412, 42 CFR 455.432, 42 CFR 455.436, and 42 CFR 455.452;

2. Screening to ensure that the providers meet all enrollment criteria for their provider type;

3. Announced or unannounced pre- and post-approval site visits; and

4. For screening purposes, utilization of databases and other sources of information to prevent enrollment of fictitious providers, to ensure that spurious applications are not processed, and to prevent fraud, waste, and abuse in the MO HealthNet Program.

(C) The screening procedures and requirements are applicable to all enrolled or applying providers. All providers are required to revalidate their MO HealthNet enrollment(s) at least every five (5) years.

(D) The following screening categories are established for MO HealthNet providers, as required by federal law and regulation for Medicare and Medicaid providers under 42 CFR section 424.518 and section 1902(kk)(1) of the Social Security Act. There are three (3) levels of screening: limited, moderate, and high. Each provider type is assigned to one (1) of these screening levels. If a provider could fit within more than one (1) screening level described in this section, the highest risk category of screening is applicable.

1. Limited Risk Category.

A. The following providers pose a limited risk of fraud, waste, and abuse to the MO HealthNet Program and are subjected to limited category screening:

(I) Physicians or non-physician practitioners (except as otherwise listed in another risk category) and medical groups or clinics;

(II) Ambulatory surgical centers (ASCs);

(III) Competitive acquisition program/Part B vendors;

(IV) End-stage renal disease (ESRD) facilities;

(V) Federally qualified health centers (FQHCs);

(VI) Histocompatibility laboratories;

(VII) Home infusion therapy suppliers;

(VIII) Hospitals, including critical access hospitals (CAHs);

(IX) Health programs operated by an Indian Health Program (as defined in section 4(12) of the Indian Health Care Improvement Act) or an urban Indian organization (as defined in section 4(29) of the Indian Health Care Improvement Act) that receives funding from the Indian Health Service pursuant to Title V of the Indian Health Care Improvement Act;

(X) Mammography screening centers;

(XI) Mass immunization roster billers;

(XII) Opioid treatment programs (if 42 CFR 424.67(b)(3)(ii) applies);

(XIII) Organ procurement organizations (OPOs);

(XIV) Pharmacies;

(XV) Radiation therapy centers (RTCs);

(XVI) Religious nonmedical health care institutions (RNHCIs);

(XVII) Rural health clinics (RHCs); and

(XVIII) Skilled nursing facilities (SNFs).

B. The providers in the limited category are subject to the following screening requirements:

(I) Verification that the applying provider, and all persons disclosed or required to be disclosed, meet all applicable federal regulations and MO HealthNet Program requirements for the provider type;

(II) Verification that the applying provider, and all persons disclosed, have a valid license, operating certificate, or certification if required for the provider type, and that there are no current limitations on such licensure, operating certificate, or certification which would preclude enrollment;

(III) Verification that the applying provider's, and that of all persons disclosed, license(s) held in any other state has/have not expired and that there is/are no current limitations on such license(s) which would preclude enrollment;

(IV) Confirmation of the identity of the applying provider and determination of the exclusion status of the applying provider and any person with an ownership or control interest or who is an agent or managing employee of the provider through routine checks of the following federal databases:

(a) Social Security Administration's Death Master File;

(b) National Plan and Provider Enumeration System;

(c) List of Excluded Individuals/Entities;

(d) The Excluded Parties List System;

(e) Medicare Exclusion Database; and

(f) Any such other databases as the Secretary of the United States Department of Health and Human Services has prescribed as of September 30, 2021, pursuant to section 455.436 of Title 42, Code of Federal Regulations, which is incorporated by reference and made part of this rule as published by the Office of the Federal Register, 7 G Street NW, Suite A-734, Washington, DC 20401, and available at its website <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455/subpart-E/section-455.436>. This rule does not incorporate any subsequent amendments and additions.

(V) Database check of the National Sex Offender Public Website;

(VI) The information from these databases shall be used to determine eligibility of the MO HealthNet provider and for verification of the identity of the applying person, the Social Security number, the National Provider Identifier (NPI), the National Practitioner Data Bank (NPDB) licensure, and any exclusion by the Department of Health and Human Services, Office of Inspector General; and

(VII) MMAC may conduct preapproval site visits prior to acceptance of an applying provider's application.

2. Moderate Risk Category.

A. The following providers pose a moderate risk of fraud, waste, and abuse to the MO HealthNet Program and are subject to moderate screening requirements:

(I) Adult Day Care providers (ADCs);

(II) Ambulance service suppliers;

(III) Community Mental Health Centers (CMHCs);

(IV) Comprehensive outpatient rehabilitation facilities (CORFs);

(V) Entities established under sections 205.968-205.973, RSMo;

(VI) Hospice organizations;

(VII) Independent clinical laboratories (ICLS);

(VIII) Independent diagnostic testing facilities (IDTFs);

(IX) Non-emergency transportation providers (NEMTs);

(X) Personal care providers, including providers billing under the Consumer Directed Services program;

(XI) Physical therapists including physical therapy groups;

(XII) Portable X-ray suppliers (PXSs);

(XIII) Revalidating Diabetes Prevention Program providers (DPPs);



(XIV) Revalidating durable medical equipment suppliers (DMEPOS);

(XV) Revalidating home health agencies (HHAs); and

(XVI) Revalidating opioid treatment programs.

B. In addition to the screening requirements for the limited risk category in paragraph (10)(D)1., the providers in the moderate risk category shall be subject to site visits prior to acceptance of an applying provider's application and are additionally subject to unannounced post-enrollment site visits.

3. High Risk Category.

A. The following providers pose a high risk of fraud, waste, and abuse to the MO HealthNet Program and are subject to high risk screening requirements:

(I) Newly enrolling or reenrolling home health agencies;

(II) Newly enrolling or reenrolling Durable Medical Equipment, Prosthetic, Orthotic, and Supplies (DMEPOS) suppliers;

(III) Newly enrolling or reenrolling DPP suppliers; and

(IV) Newly enrolling or reenrolling opioid treatment programs that have not been fully and continuously certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) since October 23, 2018.

B. In addition to the screening requirements for the limited and moderate risk categories in paragraphs (10)(D)1. and 2. of this rule, the providers and their owners must submit to a fingerprint-based criminal history report check of the Federal Bureau of Investigations (FBI) Integrated Automated Fingerprint Identification System—

(I) A revalidating provider who has already submitted fingerprints once will not be required to submit fingerprints a second time unless required by FBI protocols;

(II) Pursuant to 42 CFR section 455.434(b), the provider is responsible for the cost of supplying the fingerprints and the state and federal government will share the cost of the processing of the fingerprints and the background check; and

(III) This fingerprint-based criminal history report check applies to all persons in this risk category applying to be a provider (whether as a billing or performing provider), or an individual with a five percent (5%) or greater direct or indirect ownership interest in such provider, or a managing employee.

(E) MMAC must adjust the categorical risk level from "limited" or "moderate" to "high" when any of the following occurs:

1. MMAC imposes a payment suspension on a provider based on a credible allega-

tion of fraud, waste, or abuse by the provider; the provider has an existing Medicaid overpayment; or the provider has been excluded by the Department of Health and Human Services, Office of Inspector General or another state's Medicaid program within the previous ten (10) years. The upward adjustment of the provider's categorical risk level for a payment suspension or overpayment shall continue only so long as the payment suspension or overpayment continues; or

2. MMAC or CMS in the previous six (6) months lifted a temporary moratorium for the particular provider type and a provider that was prevented from enrolling based on the moratorium applies for enrollment as a provider at any time within six (6) months from the date the moratorium was lifted.

(F) If a person has been screened by Medicare or by another state Medicaid agency and paid Medicare or another state Medicaid agency's application fee, within two (2) years of the date of the application to MMAC, such person will not be subject to the screening requirements or application fee provided for by this rule except those screening requirements and application fee imposed pursuant to subsection (E) of this section.

(G) Any MO HealthNet Program provider not categorized by this regulation as within the limited, moderate or high risk category shall be a considered moderate risk and screened as a moderate risk.

(H) MMAC may request and consider additional information or documentation related to the eligibility criteria, if at any time during the application process it appears that the enrollment application or supporting documentation is inaccurate, incomplete, or misleading; or it appears the applying person may be ineligible to become a MO HealthNet provider.

(11) The provider shall advise MMAC, in writing, on enrollment forms specified by MMAC, of any changes affecting the provider's enrollment records within ninety (90) days of the change, with the exception of change of ownership or control of any provider which must be reported within thirty (30) days.

(A) The Provider Enrollment Unit within MMAC is responsible for determining whether a current MO HealthNet provider record shall be updated or a new MO HealthNet provider record is created. A new MO HealthNet provider record is not created for any changes, including but not limited to change of ownership, change of operator, tax identification change, merger, bankruptcy, name change, address change, payment address change, Medicare number change,

National Provider Identifier (NPI) change, or facilities/offices that have been closed and reopened at the same or different locations. This includes replacement facilities, whether they are at the same location or a different location, and whether the Medicare number is retained or if a new Medicare number is issued. A provider may be subject to administrative action if information is withheld at the time of application that results in a new provider number being created in error. The division shall issue payments to the entity identified in the current MO HealthNet provider enrollment application. Regardless of changes in control or ownership, MMAC shall recover from the entity identified in the current MO HealthNet provider enrollment application liabilities, sanctions, and penalties pertaining to the MO HealthNet program, regardless of when the services were rendered.

(12) MO HealthNet provider identifiers shall not be released to any non-governmental entity, except the enrolled provider, by the MO HealthNet Division or its agents.

(13) The provisions of this rule are declared severable. If any provision of this rule is held invalid by a court of competent jurisdiction, the remaining provisions of this rule shall remain in full force and effect, unless otherwise determined by a court of competent jurisdiction to be invalid.

(14) Except to the extent inconsistent with this rule, the requirements of 13 CSR 70-3.030 remain in force, including any provisions regarding denial of applications and termination, until those provisions are rescinded.

AUTHORITY: sections 208.159 and 660.017, RSMo 2016. Original rule filed Dec. 12, 2013, effective July 30, 2014. Amended: Filed May 26, 2015, effective Nov. 30, 2015. ** Emergency amendment filed March 11, 2022, effective March 30, 2022, expired Sept. 26, 2022. Amended: Filed March 11, 2022, effective Oct. 30, 2022.*

**Original authority: 208.159, RSMo 1979, and 660.017, RSMo 1993, amended 1995.*

***Pursuant to Executive Order 21-07, 13 CSR 65-2.020, section (5) and subsections (9)(B) and (9)(F) was suspended from March 19, 2020 through April 13, 2021.*

13 CSR 65-2.030 Denial or Limitations of Applying Provider

PURPOSE: This rule implements federal regulatory requirements promulgated by the



United States Department of Health and Human Services, Centers for Medicare and Medicaid Services at 76 Fed. Reg. 5862 (February 2, 2011), 42 CFR Parts 455 and 457, establishing the bases on which enrollment, revalidation, and establishment of a new practice location may be approved, limited, or denied.

(1) Missouri Medicaid Audit Compliance (MMAC) may terminate the provider's enrollment or deny enrollment—

(A) Where the provider did not submit timely and accurate information or did not cooperate with screening methods required under applicable statutes and regulations unless the provider cures the failure to comply with this subsection within thirty (30) days of MMAC's notice that it intends to terminate the provider or deny enrollment;

(B) Where the provider or any person with an ownership or control interest has been convicted of or pled guilty to a criminal offense, including any suspended imposition of sentence, any suspended execution of sentence, or any period of probation or parole, related to their involvement with the Medicare, Medicaid, or Title XXI program in the last ten (10) years, unless MMAC determines that denial or termination of enrollment is not in the best interests of the MO HealthNet Program and MMAC documents that determination in writing;

(C) Where the provider or any person with an ownership or control interest has been convicted of or pled guilty to a misdemeanor or felony charge, including any suspended imposition of sentence, any suspended execution of sentence, or any period of probation or parole relating to:

1. Endangering the welfare of a child;
2. Abusing or neglecting a resident, patient, or client;
3. Misappropriating funds or property belonging to a resident, patient, or client; or
4. Falsifying documentation verifying delivery of services to a personal care assistance services consumer;

(D) Where the provider or any person with an ownership or control interest has been placed on the Family Care Safety Registry as mandated by sections 210.900–210.936, RSMo; or been placed on the Missouri Sex Offender Registry as mandated by sections 589.400–589.425 and 43.650, RSMo;

(E) Where the provider is terminated under Title XVIII of the Social Security Act or under the Medicaid Program or Children's Health Insurance Program (CHIP) of any other state unless MMAC determines that the termination was not for cause, which may include, but is not limited to, fraud, integrity,

or quality. Termination or denial of enrollment will not be required if MMAC determines it would not be in the best interests of the MO HealthNet Program and MMAC receives a waiver from the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services pursuant to 42 U.S.C. 1320a-7;

(F) Where the provider or a person with an ownership or control interest or who is an agent or managing employee of the provider fails to submit timely or accurate information, unless MMAC determines that termination or denial of enrollment is not in the best interests of the MO HealthNet Program, and MMAC documents that determination in writing;

(G) Where the provider, or any person with ownership or control interest, fails to submit fingerprints in a form and manner to be determined by MMAC within thirty (30) days of a request by Centers for Medicare and Medicaid Services (CMS) or MMAC, unless MMAC determines that termination or denial of enrollment is not in the best interests of the MO HealthNet Program, and MMAC documents that determination in writing;

(H) Where the provider fails to permit access to provider locations for any site visits under 13 CSR 65-2.020, unless MMAC determines that termination or denial of enrollment is not in the best interests of the MO HealthNet Program, and MMAC documents that determination in writing;

(I) Where the provider fails to complete an application for provider direct deposit as required by 13 CSR 70-3.140;

(J) Where the provider or a person with an ownership or control interest submitted false information to MMAC; or

(K) Where the identity of any provider or person with an ownership or control interest cannot be verified.

(2) Denial of enrollment shall preclude any provider or person from submitting claims for payment, either personally or through claims submitted by any clinic, group, corporation, affiliate, partner, or any other association to the single state agency or its fiscal agents for any services or supplies delivered under the MO HealthNet program whose enrollment as a MO HealthNet provider has been denied. Any claims submitted by a non-provider through any clinic, group, corporation, affiliate, partner, or any other association and paid shall constitute overpayments.

(3) No clinic, group, corporation, partnership, affiliate, or other association may submit claims for payment to the MO HealthNet Division or its fiscal agent for any services or

supplies provided by a provider or person within each association who has been denied enrollment in the MO HealthNet program. Any claims for payment submitted and paid under these circumstances shall constitute overpayments.

(4) Except to the extent inconsistent with this rule, the requirements of 13 CSR 70-3.030 remain in force, including any provisions regarding denial of applications and termination, until those provisions are rescinded.

(5) The provisions of this rule are declared severable. If any provision of this rule is held invalid by a court of competent jurisdiction, the remaining provisions of this rule shall remain in full force and effect, unless otherwise determined by a court of competent jurisdiction to be invalid.

AUTHORITY: sections 208.159 and 660.017, RSMo 2016. Original rule filed Dec. 12, 2013, effective July 30, 2014. Amended: Filed Aug. 20, 2021, effective March 30, 2022.*

**Original authority: 208.159, RSMo 1979, and 660.017, RSMo 1993, amended 1995.*