Provider Communication Bulletin #8
January 31, 2013

IN THIS BULLETIN:

General Information

February Provider Forums will be held on February 12 and 14, 2013. RSVPs are not required but do assist staff in preparation for the event.

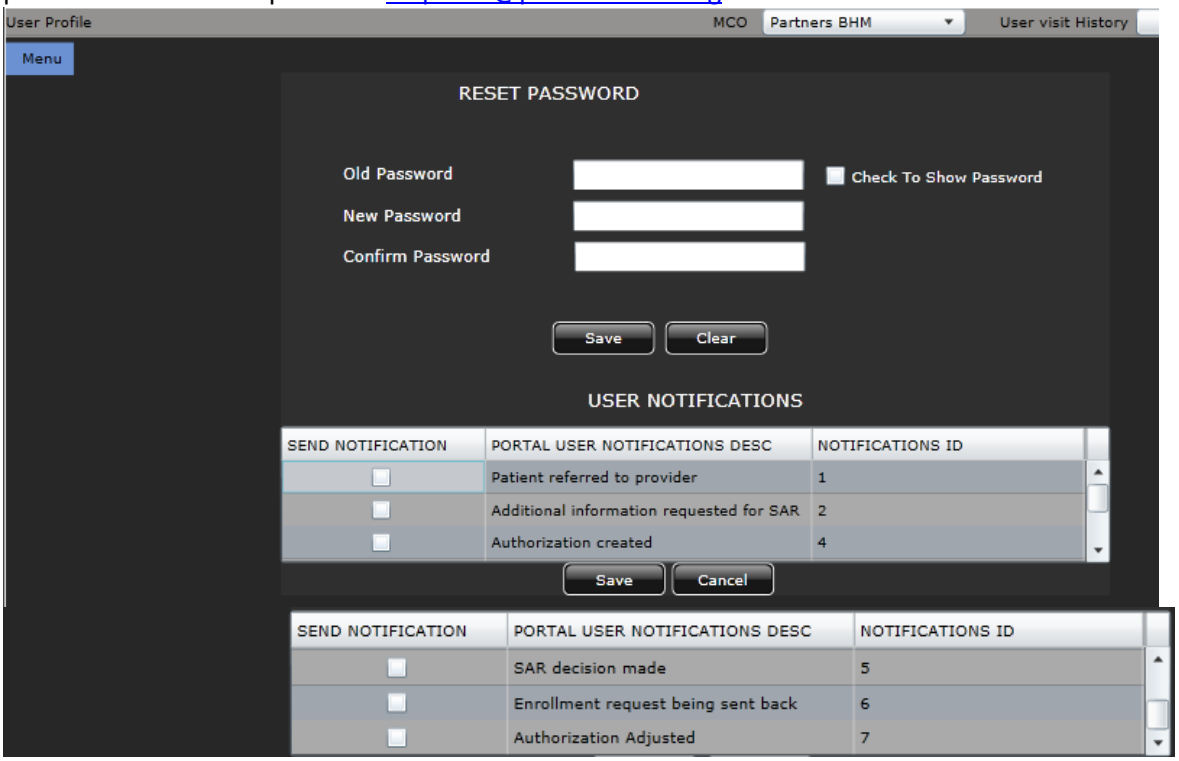
- **Gastonia**: Feb. 12, 2013; 1-4 PM; Partners BHM Auditorium, 901 S. New Hope Rd., Gastonia NC 28054. To RSVP, click here.
- **Morganton:** Feb. 14, 2013, 8:30-11:30 AM; Foothills Higher Education Center, Room #HEC163, 2128 South Sterling Street, Morganton, NC. To RSVP, click here.
- **Statesville:** Feb. 14, 2013, 1-4 PM; NEW LOCATION-- Iredell County Public Library—Rooms A & B, 201 N. Tradd St., Statesville, NC 28677. To RSVP, click here.

AlphaMCS Online Training: Partners BHM will continue to offer AlphaMCS Online Trainings for those providers that have not participated in the necessary training. Online training dates for February will be posted to the Partners BHM website calendar by Monday, February 4, 2013. If you have participated in AlphaMCS training through another MCO, you do not need to participate in a Partners online training to obtain a Partners AlphaMCS log in.

To obtain a Partners BHM AlphaMCS log in, you must complete the AlphaMCS Staff Log In Request form located at http://www.partnersbhm.org/providers/alphamcs.aspx. A form must be completed for each individual log in and submitted to the Help Desk at HelpDesk@PartnersBHM.org. You will receive an email from the Help Desk once the log in is activated.

AlphaMCS Alerts: Providers can receive alerts, through AlphaMCS, if additional information is needed for Service Authorization Requests—the user simply has to modify his or her user options to receive the alerts. To activate the alerts function, the user needs to enter AlphaMCS, select Menu, User Profile, and check the boxes appropriate to the alerts you need to receive. See the screenshot below.

All providers using AlphaMCS are urged to view his or her user profile and select the appropriate notifications so you are better informed about items needed to ensure that authorizations are properly submitted. If you have a question about the function, or have problems with your login or password, please contact the Help Desk at helpdesk@partnersbhm.org or call 704-842-6431.



Letter to Medicaid Recipients Regarding 1915 (b)/(c) Waiver: The Division of Medical Assistance mailed a letter to Medicaid recipients in Burke, Catawba, Cleveland, Gaston, Iredell, Lincoln, Surry and Yadkin on January 18, 2013. The letter informed recipients that Partners Behavioral Health Management will be responsible for authorization and management of Medicaid-funded behavioral health services effective February 1, 2013. Partners BHM has staff on hand to assist callers, and has developed a series of frequently asked questions and answers for providers, Departments of Social Services, and local health departments in case individuals contact the agencies with questions. Partners BHM appreciates any assistance in communicating information to our consumers. If a consumer has additional questions, please refer the person to Partners BHM at 1-877-864-1454. To view frequently asked questions, visit www.partnersbhm.org/aboutus/.

Partners BHM's Rates for NC Innovations: Services and Supplies are posted to the Partners website on the For Providers/Information and Documents page under "Provider Information". Click here to view the document.

Provider Agencies selected for "Community Guide" and "Agency with Choice" Services: In December 2012, Partners BHM issued a Request for Proposals for operation of two B3 services—

"Community Guide" and "Agency with Choice." The following provider agencies have been selected to offer these services within the Partners BHM Network:

Community Guide:	**Agency with Choice:**
Arc of North Carolina	Arc of North Carolina
Easter Seals/UCP	Easter Seals/UCP
Turning Point Services	Skill Creations
True Behavioral Healthcare	Turning Point Services

Contracting with Partners BHM

Effective February 1, 2013, only providers with a fully executed contract with Partners BHM will be eligible for claims submission and reimbursement for services rendered for consumers with Medicaid eligibility within the Partners' eight county service area.

Effective midnight, January 31, 2013, the Partners BHM Provider Network will close for provider applications until April 1, 2013. Any expansion of the Network between February 1 –March 30, 2013 will occur through a Requests for Proposal process as needed for specific service needs.

It is the responsibility of providers not contracted within the Partners BHM Provider Network by February 1, 2013 to transition Medicaid consumers to a Partners BHM Network Provider. Please refer to Provider Communication Bulletin #6 (issued November 6, 2012) for details and contact information.

Information About Authorizations/Utilization Management

If you have any questions regarding the information below, you may contact the Utilization Management Department at 1-866-864-1454, option 4, option 5

Documentation requirements for a SAR to be processed: Utilization Review/Utilization Management Staff will review and make a formal decision on a Service Authorization Request when a complete request is received. For a request to be considered complete, it must contain the following elements:

- Service Authorization Request
- Person Centered Plan or Individual Support Plan (required for Innovation Waiver)
- Level of Care form (required for Innovations Waiver and ICF-MR Facilities)
- North Carolina Support Needs Assessment Profile (required for NC SNAP)/Supports Intensity Scale (SIS) (required for I/DD Services/Innovations Waiver)
- Service Order (required for Medicaid Services only)
- Certificate of Need (CON) (required when necessary)
- All other supporting documentation such as a
    - Psychiatric Evaluation
    - Diagnostic Assessment
    - Comprehensive Clinical Assessment
    - Medication follow up notes and/or a Psychological Testing
- Risk Assessment (Innovations Waiver)

Utilization Management also asks that you include the name of the Clinician submitting the request and contact information in case there are additional questions.

Failure to submit a complete request may result in an administrative denial "Unable to Process" without appeal rights. A complete request means all of the necessary supporting clinical documentation that covers the full period of authorization requested, which includes a valid Person Centered Plan that covers the clients services until the end of the requested period is included.

Medicaid Authorization Requests: Providers should continue to submit Medicaid Authorization requests to Value Options with start dates through January 31, 2013. Effective February 1, 2013, all authorization requests will need to be submitted to Partners BHM through the AlphaMCS system, including authorizations for the Innovations Waiver.

Providers are reminded that authorizations need to be submitted 10 days prior to the previous authorization end date.
Example:

- If you have an authorization that ends on January 31, 2013, you need to submit the authorization to Partners BHM *10 days prior to the end date* (submit by January 21, 2013).

Transfer of authorizations from Value Options to Partners BHM: As you are aware, Value Options provided Partners Behavioral Health Management with information about authorizations your agency currently has in place. This information included all Medicaid services with the start and end dates and units that were authorized.

In a review of the data from Value Options, it was identified that some of the authorizations' end dates exceeded the benefit limit for how long a service can be authorized. In those cases, the end date on the current Value Options authorization was shortened to be in compliance with the service definition. No authorization imported from Value Options will go beyond June 30, 2013 in the Partners BHM system.

Since Partners BHM is the new contracting partner, this will not be considered a reduction in services, nor will appeal rights apply. Many of the authorizations Partners received from Value Options were entered exactly as received because their end date matched the benefit plan and ended prior to or by June 30, 2013.

Partners BHM strongly urges all providers to review their current authorization information to determine when to send a new authorization request to Partners for ongoing services.

Initial Authorizations versus Concurrent Authorizations: The first Service Authorization Request submitted to Partners BHM for a specific consumer and specific service will be reviewed as an *initial authorization,* even if there was a concurrent authorization through Value Options. Initial benefit limits and documentation requirements will apply.

If the SAR is sent as a concurrent request, it will be returned as an Administrative Denial with no appeal rights. This procedure will apply for SARs submitted with a start date of February 1, 2013 forward.

As noted above, Partners BHM will import current authorizations from Value Options. All requests sent prior to the end date of the previous Value Options authorization will also be reviewed as an initial request.

Medicaid Psychiatric Inpatient Authorization Process: Partners BHM is modifying the authorization rules for Medicaid psychiatric inpatient services under the Prepaid Inpatient Health Plan effective February 1, 2013.
Initial authorizations for inpatient services for Medicaid enrollees will be provided for an initial three days of care. The authorization begins with the admission day; does not include the day of discharge, and; is considered a pass through where the review of the Service Authorization Request occurs after the admission.

A review will need to be conducted with Partners BHM Utilization Management prior to the third day. The grid below outlines the time frames for the review:

When the admission to psychiatric inpatient hospital services occurs	The Hospital will contact the Partners BHM Utilization Management Department
Saturday through Wednesday	Approximately 48 hours following the admission to either provide the plan for discharge on the third day OR to provide the medically necessary information to support a request for additional days of service beyond the third day
Thursday	On the next weekday (Friday), to either provide the plan for discharge on the third day OR to provide the medically necessary information to support a request for additional days of service beyond the third day
Friday	On the next weekday (Monday), to either provide the plan for discharge on the third day OR to provide the medically necessary information to support a request for additional days of service beyond the third day

In all cases, the hospital assumes the financial risk if the patient is retained in psychiatric inpatient hospital services for longer than three days and is not approved for additional days.
Hospitals can contact Partners Utilization Management staff assigned specifically to hospital inpatient care at 1-877-864-1454, option 4, option 5, then option 3. Hospital staff should follow the established processes for requesting services either through Alpha MCS system or through a live review.

Authorizations for Enrollees transitioning from CAP-MR/DD Waiver to NC Innovations Waiver: All authorizations for enrollees transitioning to the NC Innovations Waiver must be approved at this time (instead of at the enrollee's original review date). Partners BHM staff are working diligently to enter these authorizations into AlphaMCS with a targeted completion date of February 15.
All NC Innovations Service Authorization Requests entered by February 15 to start February 1, 2013 will be entered with a start date of February 1, 2013. Authorizations will be approved or denied within 14 calendar days of the entered request (i.e. February 28, 2013). This decision is to ensure that consumers continue to receive services and provider agencies are paid in a timely manner. If you have questions regarding this decision, contact Partners I/DD Utilization Management at 1-877-864-1454, option 4, option 5, option 2.

Care Coordination Transition

Mental Health/Substance Abuse Targeted Case Management and Intellectual/Developmental Disabilities Targeted Case Management will no longer be available in the service array as of Friday, February 1, 2013. Many providers have asked if they need to submit an authorization for Care Coordination. The answer to this question is ***No***.

What is Care Coordination?
Care Coordination is an administrative function within Partners BHM's managed care system that is designed to proactively intervene and ensure optimal care to at-risk consumers in designated special healthcare needs populations. It is available to members in all three disability groups (Mental Health, Substance Abuse, and Intellectual/Developmental Disability).

Partners BHM's Intellectual/Developmental Disabilities Care Coordination unit has worked directly with Provider Agencies to identify individuals currently receiving services that meet the criteria for I/DD Care Coordination.
Providers that are 'keepers of the plan' may make a referral for I/DD Care Coordination should the needs of the individual have changed and they meet I/DD Care Coordination criteria.

- To make a referral, please request an application from the appropriate regional IDD Care Coordination Supervisor.
- IDD Care Coordination Supervisors will screen referrals for eligibility determination.
- If eligible, individual will be assigned to an IDD Care Coordinator.
- If the individual is deemed not to be eligible, written notification will be mailed to the legally responsible person.
    - The family may file a grievance to have a second clinical documentation review for eligibility

Families may continue to contact Customer Service at 1-888-235-4673 to inquire about I/DD Care Coordination.

Partners BHM's Mental Health/Substance Abuse Care Coordination unit has worked directly with Provider Agencies to identify individuals currently receiving services that meet criteria for Care Coordination. MH/SA Care Coordination is not a transition from MH/SA Targeted Case Management. *Unless the consumer meets the special healthcare population criteria as indicated below, they will not meet the criteria for MH/SA Care Coordination*. Please review the information below as a guide for MH/SA Care Coordination at Partners BHM. **Consumers are identified for MH/SA Care Coordination, not referred.**

MH/SA CC activities include the identification, coordination and monitoring of, linkage to behavioral health treatment services, rehabilitative, and/or facilitative services and supports depending on the consumer's individual needs and funding source.

Care Coordinators:

- Assist consumers who are at high risk for hospitalization or institutionalization.
- Verify that consumers being discharged from Inpatient facilities (state and community hospitals, facility based crisis services, detoxification services) and mobile crisis without a behavioral health home have a scheduled appointment with a community provider within seven calendar days of discharge.

- Ensure consumers who do not attend scheduled appointments are contacted to reschedule services within five calendar days.
- Monitor the consumer's care across the continuum of care.
- Work collaboratively to improve outcomes for the consumer.
- Reinforce that consumers receive:
    1. Appropriate clinical assessment
    2. Collaborative and Individualized Treatment planning
    3. Access to clinical and medical specialists.

Care Coordination vs. Case Management

Care Coordination is a set of activities by which a system of care assures that every person served by the system has a single care or service plan that is individualized and coordinated, not duplicative, and within prescribed parameters designed to assure cost effective and good outcomes. Its goal is managing and stretching limited resources, as well as assuring the best quality care possible to achieve the clients' service goals. Care Coordination can also provide consultation to clinicians both within and outside of the provider network regarding alternative and creative approaches to care. Care Coordination is less often provided face to face with the client; rather contact is frequently with providers or clinicians and may be done by telephone as well as face to face.

What are Special Healthcare Needs Populations and High Risk/High Cost Consumers?

Partners BHM provides Care Coordination for two populations: **Special Healthcare Needs** and **High Risk and High Cost** consumers.

Designated *Special Healthcare Needs* populations for Mental Health and/or Substance Use/Addiction Care Coordination include the following:

Child Mental Health

- Children who have a diagnosis within the diagnostic ranges defined below:

Diagnostic Range	Diagnosis or Disorder Classification
293-297.99	Disorders due to General Medical Condition
298.8-298.9	Psychotic Disorder, Psychotic Disorder NOS
300-300.99	Mood Disorders, Anxiety Disorders, Dissociative Disorders, Factitious Disorders, Somatoform Disorders, Unspecified Mental Disorder
302-302.6, 302.8-302.9	Sexual & Gender Identity Disorders
307-307.99	Eating Disorders, Tic Disorders, Sleeping Disorders
308.3	Acute Stress Disorder
309.81	PTSD
311-312.99	Depressive Disorder NOS, Impulse-Control Disorders Not Elsewhere Classified
313.81	Oppositional Defiant Disorder
313.89	Reactive Attachment Disorder
995.5-995.59	Neglect, Physical or Sexual Abuse of Child (victim)
V61.21	Physical or Sexual Abuse of Child (perpetrator)

AND Current CALOCUS Level of VI,
OR who are currently, or have been within the past 30 days, in a facility (including a Youth Development Center and Youth Detention Center) operated by the DJJDP or DOC for whom Partners BHM has received notification of discharge.

Adult Mental Health

- Adults who have a diagnosis within the diagnostic ranges of:

Diagnostic Range	Diagnosis or Disorder Classification
295-295.99	Schizophrenic & Schizoaffective Disorders
296-296.99	Major Depressive, Bipolar & Mood Disorders
298.9	Brief Psychotic Disorder
309.81	PTSD

AND Current LOCUS Level of VI

Substance Dependent

- Consumers with a substance dependence diagnosis **AND** Current ASAM PPC Level of III.7 or higher

Opioid Dependent

- Consumers with an opioid dependence diagnosis **AND** who have reported to have used drugs by injection within the past 30 days

Co-Occurring Diagnoses

- Consumers with both a mental illness and a substance abuse diagnosis **AND**
  Current CALOCUS/LOCUS of V or higher, OR current ASAM PPC Level of III.5 or higher.
- Consumers with both a mental illness diagnosis and an IDD diagnosis **AND**
  Current LOCUS/CALOCUS of IV or higher.
- Consumers with both an IDD diagnosis and a substance abuse diagnosis **AND**
  Current ASAM PPC level of III.3 or higher.

High Risk/High Cost Consumers

High Risk Individuals are defined as:

- Needing emergent crisis services three or more times in the previous 12 months
- First service is Emergency services, Mobile Crisis Intervention or ED primary behavioral health intervention and do not have a behavioral health home
- Requiring MH/DD/SA services and have been discharged from a state facility, community hospital or specialty hospital, emergency department, facility based crisis service, or detox service.
- Consumers without a behavioral health home who are being discharged from Inpatient facilities (state and community hospitals, detox, and facility based crisis) or emergency services that are not engaged with a behavioral health provider

High Cost Consumers are individuals whose treatment plan is expected to incur costs in the top 20% for all consumers in a disability group. High Cost consumers are identified by reviewing claims reports.

Consumers without a Behavioral Health Home

North Carolina Division of Mental Health/Developmental Disability/Substance Abuse Services also identifies high risk consumers for whom Care Coordination (CC) activities should occur. These

populations include consumers without a behavioral health home who are being discharged from Inpatient facilities (state and community hospitals, detox, and facility based crisis) or emergency services. A Behavioral Health Home may be a licensed independent practitioner, enhanced service provider, direct care provider or CABHA. Care Coordination is not designed to usurp the role of the Behavioral Health Home.

Care Coordination activities may include participating on-site in discharge planning for consumers being discharged from state hospitals and alcohol and drug abuse treatment centers and other important community partner providers and agencies continuing to work with the consumer and CCNC/medical home until the consumer is connected to a clinical behavioral health home.

Partners BHM CC staff is to ensure that individuals who are being discharged from DHHS state facilities and community inpatient hospital services, detoxification facilities, and facility based crisis centers are seen by a community provider within seven calendar days of discharge. As applicable, also ensure that consumers who do not attend scheduled appointments are contacted to reschedule services within five calendar days.

Outpatient Commitments

Partners BHM shall provide MH/SA CC activities for its consumers who are under an Outpatient Commitment (OPC) order. This includes maintaining up-to-date records on each consumer in the catchment area with an OPC order, including the name or names of their treatment provider(s) and documentation of CC contacts to verify the consumer's compliance with the OPC order in working with the clinical provider. If the Care Coordinator determines that the consumer has failed to comply or clearly refuses to comply with all or part of the prescribed treatment, the CC shall report such failure as required by law and take action as necessary to assure the safety of the consumer and the public.

How are Consumers Identified for MH/SA Care Coordination?

Consumers are identified for MH/SA Care Coordination within Partners BHM through data monitoring, reporting and through clinical alerts from various departments. The MH/SA Care Coordination Regional supervisor assigns consumers who meet the aforementioned Special Healthcare Population criteria and assigns the case to an appropriate care coordinator.

Partners BHM System of Care should be notified of children who are at risk for out of home placements in specific Level III, IV, Psychiatric Residential Treatment Facility (PRTF), Wright School, Whitaker PRTF, and all out of state placements. Partners BHM encourages providers to communicate early on in the process for children at risk of out of home placement to minimize barriers in authorization.

It is important to note that before a referral is made to residential level III, IV, PRTF, Wright School, Whitaker PRTF, and all out of state facilities the case must be presented to the Local County Care Review Team.

The following information articulates the how the care review process works:

- Provider, parent, someone from the community (which may include local schools, Department of Social Services, etc.) calls Customer Service/Access by calling 1-888-235-(HOPE) 4673 or contacts Partners BHM in some way asking for out of home placement for a child/adolescent.
- Call is documented in Customer Service/Access via call log and then is transferred to System of Care (SOC) department.
- SOC will educate the provider/family about the Care Review Process.

- If after the Care Review Process is completed and that process indicates the need for a referral to Child/Adolescent Level III, IV, or Psychiatric Residential Treatment Facility (PRTF) level of care, Wright School, Whitaker PRTF, and/or any out of state placement, then SOC or the behavioral health clinical home can refer to MH/SA CC.

Delineation of Roles for Authorization Requests & Person Centered Plan Development

The decision of who is best to develop the PCP for adults and/or children shall be determined by either the Child and Family Team members (for children/adolescents), the treatment team members (consumer/family, behavioral health/medical provider, LME/MCO Care Coordinator, stakeholder, family partners, other).

The following is a guide of Partners BHM expectations regarding PCP development and authorization requests:

For Adult/Child consumers receiving MH/SA TCM and an ENHANCED SERVICE, the following table identifies who is responsible for the Service Authorization Requests and Person Centered Plan Development:

Enhanced Service	Responsible for Service Authorization Request
Intensive In Home Service	Intensive In Home Provider
Multi-Systemic Therapy	Multi-Systemic Therapy Provider
Child/Adolescent Day Treatment	Child/Adolescent Day Treatment Provider
Residential Level II Therapeutic Foster Care	Residential Level II Therapeutic Foster Care Provider
Residential Level II Group Care	Residential Level II Group Care Provider
Residential Level III Group Care	Residential Level III Group Care Provider
Residential Level IV Group Care	Residential Level IV Group Care Provider
Psychiatric Residential Treatment Facility	Psychiatric Residential Treatment Facility Provider
Partial Hospitalization	Partial Hospitalization Provider
Assertive Community Treatment Team	Assertive Community Treatment Team Provider
Community Support Team	Community Support Team Provider
Psychosocial Rehabilitation	Psychosocial Rehabilitation Provider
Substance Abuse Intensive Outpatient Provider	Substance Abuse Intensive Outpatient Provider
Substance Abuse Comprehensive Outpatient Treatment	Substance Abuse Comprehensive Outpatient Treatment
Adult Group – Residential Living	Adult Group – Residential Living

For Adult/Child Consumers receiving MH/SA TCM and an OUTPATIENT SERVICE, the following table identifies who is responsible for the Service Authorization Requests and Person Centered Plan Development:

Service	Responsible for Service Authorization Request
Outpatient	Outpatient Service Provider

For Consumers currently in an Inpatient setting:

- If a behavioral health clinical home provider was involved with the consumer prior to placement in the inpatient setting, then the clinical home should be coordinating care for consumers return to home.
- If there is no clinical home involved with the consumer, then the inpatient provider will contact Customer Service/Access to Care for hospital discharge appointment within seven

days. Consumer will then be connected to behavioral health clinical home provider and that provider will be responsible for coordinating care. Consumers in an inpatient setting will also meet the criteria for MH/SA Care Coordination and will be working with MH/SA Care Coordination for treatment planning purposes and coordination of care to work with the consumer to ensure connectivity to a behavioral health clinical home. This referral to MH/SA Care Coordination occurs through our Customer Service/Access to Care department at the time that the hospital discharge appointment is made.

- If there is more than one provider involved with the consumer, then the higher level or more intense service, will be the keeper of the plan and responsible for Person Centered Plan development. For an example, when a consumer is receiving Residential Level III and Child and Adolescent Day Treatment, the Residential Level III Provider is the more intense service; however, Child and Adolescent Day Treatment has the Case Management component. In this situation, the two providers will need to decide who will act as the behavioral health clinical home and both share responsibility for input into the Person Centered Plan (PCP) development and maintenance. The same applies for adult residential services, outpatient therapy and ADVP. There will need to be an agreement as to who will act as clinical home.

Behavioral Health Clinical Home Provider: A clinical home is the provider who is responsible for the following activities:

a. Assuring that a Comprehensive Clinical Assessment is completed
b. Development, implementation and revision of a person-centered plan and crisis plan
c. Coordination of all service among providers
d. Completing the enrollment information in AlphaMCS **or** providing enrollment information to Partners Behavioral Health Management
e. Requesting authorization (each provider organization will request their own authorization)
f. For children, Clinical Home is responsible for convening the Child and Family Team
g. First responder services which is the first point of contact for the consumer who experiences a crisis; Note that face to face contact is expected.
h. Assessment of and coordination of both physical and behavioral healthcare needs

Enhanced services tend to be more comprehensive and Enhanced Providers are designated as the clinical home provider for the consumer.

Psychiatric Residential Treatment Facilities and Residential Providers will be responsible for entering their Service Authorization Requests in AlphaMCS, completing and maintaining the Comprehensive Clinical Assessment and the Person Centered Plan.

Partners BHM Utilization Management Department requests a current Comprehensive Clinical Assessment on file for all consumers in a residential level of care at least annually.

All providers are expected to respond telephonically 24/7/365 to their consumers who may have a crisis even if they do not have first responder responsibilities per the service definition.

State Information

Implementation Update #100 was posted on January 28, 2013 and is available on the Division of MH/DD/SAS website at http://www.ncdhhs.gov/mhddsas/implementationupdates/index.htm.

A number of **Special Medicaid Bulletins** have been released by the NC Division of Medical Assistance in January. Click on the underlined text below to access the bulletins.

- January 2013 - SPECIAL BULLETIN - CAP I/DD Waiver Transitions in Mecklenburg County
- January 2013 - SPECIAL BULLETIN - 1915 (b)/(c) Waiver Expansion in Mecklenburg County
- January 2013 - SPECIAL BULLETIN - Addition of Medical Evaluation and Management (E/M) Codes for Use by Psychiatric Nurse Practitioners
- January 2013 - SPECIAL BULLETIN - Services and Local Management Entity-Managed Care Organizations (LME-MCOs)
- January 2013 - SPECIAL BULLETIN - Behavioral Health CPT© Code Changes for Psychotherapy and Psychodiagnostic Interviewing

Partners Behavioral Health Management communicates Provider Information through Provider Communication Bulletins, its website, www.PartnersBHM.org, and the "Monday Coffee Break" newsletter. If you have any questions regarding this Bulletin, please reference the contact within the topic or contact your provider specialist. All Provider Bulletins and training event information are posted at www.PartnersBHM.org.