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MEMORANDUM

TO: Joint Legislative Oversight Committee Members on HHS Commission for MH/DD/SAS
Local CFAC Chairs State CFAC
NC Council of Community Programs NC Assoc. of County Commissioners
County Managers County Board Chairs
State Facility Directors LME Directors
LME Board Chairs DHHS Division Directors
Advocacy Organizations Provider Organizations
MH/DD/SAS Stakeholder Organizations NC Assoc. of County DSS Directors

FROM: Dr. Craigan L. Gray
Steven Jordan *SS*

SUBJECT: Implementation Update #90
Enrolling Medicaid/Health Choice in CCNC/CA Guidance for Electronic Signatures
Changes in Behavioral Health for Health Choice Fraudulent Trends in Outpatient Services
New UR Guidelines for Residential Reporting Provider Fraud & Abuse
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CAP-I/DD Policy for Exception/Extension CABHA Key Staff Changes
CAP-MR/DD Waiver Slots/MFP Slots Update

Enrolling Medicaid and Health Choice Recipients in Community Care of North Carolina /Carolina Access

In an effort to avoid further budget reductions, it is critical that the Medicaid system achieve savings to preserve vital services. One of their primary ways to do so is to enroll all eligible Medicaid and Health Choice recipients into Community Care/Carolina Access "health homes." These efforts need to be a priority if we are to preserve the existing range of optional Medicaid funded services.

What providers can do to assist with enrollment to Community Care of North Carolina (CCNC)/Carolina Access (CA):

- Check the recipient's Medicaid card. If the card does not have a primary care physician on it, refer the recipient to the local Department of Social Services (DSS) office to enroll in the CCNC/CA network.

- The recipient may choose a medical home with a primary doctor. The local county DSS has a complete list of participating doctors. A medical home can be chosen for each family member. If a recipient does not choose a medical home, one will be automatically assigned.
- Give the recipient a Carolina ACCESS Member Handbook (PDF, 899 KB). This book can be your guide when explaining the benefits and requirements of being a member of CCNC.
 - You can order handbooks by contacting the Division of Medical Assistance (DMA), Managed Care Section, at 919-855-4780 or faxing a request to the Managed Care Section at 919-715-0844 or 919-715-5235.
 - It is also located on the DMA website at <http://www.ncdhhs.gov/dma/ca/carehandbook.pdf>
- Explain the benefits of being a member of CCNC/CA.
 - A medical home with a primary care provider (PCP). The medical home is a place for well check-ups, sick visits, treatment of special health care needs, etc.
 - Medical advice available 24/7. There is no need to go to the emergency room unless the problem risks life or health without immediate treatment.
 - Coordinated medical services so that recipients receive necessary care either by the PCP or by a referral to a specialist. The PCP will help find the right specialist.
 - Arrangements for hospitalizations when necessary. (Inform recipients which hospital the PCP admits to.)
 - Care management services available through the CCNC/CA network.
- Follow up with the local DSS to ensure the recipient has been enrolled in the CCNC/CA network.

Changes in Behavioral Health Authorizations and Billing for Health Choice

The Division of Medical Assistance is working to align all Behavioral Health policies and service definitions for Health Choice recipients with Behavioral Health Medicaid policies. The target date for this transition is October 1, 2011. All requests for authorization submitted to ValueOptions on or after October 1st will use the Medicaid service criteria. **As a reminder, the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Special Provision and the Important Notes on EPDST documented in Medicaid clinical coverage policies do not apply to NC Health Choice.**

For outpatient treatment services: The count of unmanaged visits will begin anew on October 1st under the 16 unmanaged limitations. This will occur again on January 1, 2012 and conform to the standard calendar year limitation. These visits are defined by the number of procedure codes paid for services rendered to the recipient and not by the individual units of service provided. The data system counts each procedure code as one visit with the exception of the following codes for group therapy: 90849, 90853, 90857, H0005, and H004 HQ. These five codes are counted as ½ visits for the unmanaged unit counts. When the recipient reaches the maximum number of unmanaged units the following visits will be denied unless prior approval is obtained. Once prior approval is on file for the recipient, the system considers the unmanaged count as "used" for that calendar year, regardless of the amount of previous services provided.

For Therapeutic Foster Care: On and after October 1, 2011, all Therapeutic Foster Care (TFC) authorizations for Health Choice will be made to the local management entity (LME) associated with the recipient's county of eligibility on file with DMA eligibility as of the date of review. The authorization process for TFC for Health Choice will mirror the process for Medicaid. LMEs will access copies of TFC authorization letters and adverse determination letters online via the Utilization Review (UR) vendor.

For all Health Choice Behavioral Health services: Claims adjudication for authorized services rendered prior to October 1, 2011 will occur through Blue Cross Blue Shield (BCBS). Claims adjudication for authorized services rendered on or after October 1, 2011 will occur through HP Enterprise Services. It is critical that providers use the October 1st date to separate their claims so that uninterrupted payment may occur.

New Utilization Review Guidelines for Residential Behavioral Health Providers

As per legislation, Session Law, House Bill 200 on pages 126 –127:

- Effective November 1, 2011, a comprehensive clinical assessment (CCA) completed and signed by a licensed mental health professional within 30 days of the requested admission date must be submitted with the ITR for initial reviews to assure the appropriateness of placement. Requests for transfer from one Level III or Level IV facility to another do not require a new CCA completed if the transfer is for

the same level of care. Please see Implementation Update #36 for more information regarding comprehensive clinical assessments.

- Effective November 1, 2011, a psychiatric or psychological assessment is required for authorization requests past the 180 day mark, to be completed by a psychiatrist (MD/DO) or psychologist (PhD) within 60 days of the requested start date of the requested re-authorization period. This psychiatric or psychological assessment must be completed by an independent practitioner who is not associated with the residential services provider if the provider is not a Critical Access Behavioral Health Agency (CABHA). If the residential services provider is a certified CABHA the assessment may be completed by a professional associated with the CABHA. The UR vendor will require a statement from the independent evaluator who completes the CCA for the non-CABHA attesting that he or she is independent from, and not employed by or under contract with, the residential provider seeking prior authorization for services. When prior authorization is being requested by a CABHA, the UR vendor will require a statement signed by the CABHA Clinical Director that the person completing the assessment is employed by or under contract with the CABHA.
- Documentation in the request for an extension past the 180 day mark must support that a Child and Family Team has reviewed goals and treatment progress and that the child or adolescent's family or discharge setting is involved in treatment planning and engaged in the treatment interventions.
- Independent assessments for extensions on Level III and Level IV past the 120 day mark are no longer required for requests for prior authorization.
- Providers will continue to submit an updated discharge summary but it will no longer need to be signed by the System of Care coordinator at the time of submission.

Electronic Prior Approval Requests

Mandatory Electronic Submission of Authorization Requests

Effective October 1, 2011, the Appropriations Act of 2011 (House Bill 200) mandates that providers submit authorization requests electronically via the vendor's website. For purposes of submitting mental health, substance abuse, and developmental disability requests to the appropriate utilization review vendors, please note the following information for submission:

ValueOptions

ValueOptions continues to offer live webinar training on ProviderConnect submission. Providers unable to participate in live webinar training can access pre-recorded webinars for self-paced training. Navigate to the link below and scroll to the *Provider Training Opportunities* section to view webinar details and access additional ProviderConnect resource documents such as the ProviderConnect User Guide, Quick Reference Guide, and Frequently Asked Questions (FAQ) document:

http://www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm

Eastpointe Human Services Providers

For purposes of submitting mental health, substance abuse, intellectual and other developmental disability requests to Eastpointe Human Services, providers should utilize the LME ProviderConnect web portal at <https://carelink.carenetasp.com/EastpointePC/>.

Eastpointe providers can access pre-recorded webinars for self-paced training. Navigate to the link below and scroll to the bottom of the page and see the section labeled *Webinars*. Providers can also view additional Medicaid utilization review materials from this page.

<http://www.eastpointe.net/providers/MedicaidUR/mur.aspx>

The Durham Center Providers

For purposes of submitting mental health, substance abuse, intellectual and developmental disabilities (I/DD) and CAP I/DD requests to The Durham Center, providers should utilize the ProviderConnect web portal: <https://carelink.carenetasp.com/DurhamPC/>

The Durham Center will be providing several live webinars in the coming months. Please visit the Durham Center's training/events calendar located on their website or use the following link to get directly to the calendar: <http://www.durhamcenter.org/index.php/provider/calendar>. Providers unable to participate in live

webinar training can access pre-recorded webinars for self-paced training. Navigate to the link below and scroll to the *ProviderConnect* section to access a recorded webinar and to access the Durham Center ProviderConnect User Manual. The webinar and user manual will provide information regarding obtaining a ProviderConnect user name and password <http://www.durhamcenter.org/index.php/provider/docs/service>.

Pathways LME Providers

For the purpose of submitting CAP I/DD requests to Pathways LME, providers should utilize the following link and select “CAP MR/DD Authorization Request”:

<http://www.pathwayslme.org/capur/>

The “CAP MR/DD Authorization Request” link is under construction at this time. Please visit Pathways LME website for updates on electronic submissions and trainings they will be providing.

Crossroads Behavioral Healthcare Providers

For the purpose of submitting CAP I/DD requests to Crossroads Behavioral Healthcare, providers should utilize the following ProviderConnect web portal:

<https://carelink.carenetasp.com/crossroadspc/login.asp>

Crossroads providers can access a ProviderConnect presentation at the link below and select “CAP MR/DD UR” and scroll down to Provider Training Presentations:

<http://crossroadsbhc.org/>. To obtain a login and/or individualized training on Provider Connect, you can contact Pat Draughn at pdraughn@crossroadsbhc.org.

Therapeutic Foster Care Requests Submitted Online Via ValueOptions ProviderConnect:

Therapeutic Foster Care requests can be submitted on ValueOptions ProviderConnect using any Medicaid Provider Number available to the submitting provider. The Medicaid Provider Number included on the submission will be replaced by ValueOptions staff with the appropriate LME Medicaid Provider Number corresponding to the recipient’s county of eligibility at the time of review.

Therapeutic Foster Care providers that do not have any Medicaid Provider Number should visit the website below to learn how to obtain a “ValueOptions provider number” which will allow for online submission of TFC requests via the ValueOptions ProviderConnect online provider portal

http://www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm.

CAP-I/DD Policy Requirements Extension and Exception Process

THIS RESCINDS THE EXTENSION/EXCEPTION PROCESS FOR CAP-MR/DD WAIVER RECIPIENTS POSTED IN IMPLEMENTATION UPDATES IN #76 AND # 80.

Implementation Updates #76 and #80, and Form and Instructions posted on the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) website on October 1, 2010 and revised November 1, 2010 set forth an erroneous Extension/Exception Request Process for the limit of 129 hours per month of habilitation services for adults. DMA is RESCINDING the requirement to request an exception because the 129 hour limit does not go into effect until November 1, 2011. For the remainder of this waiver, which is ending October 31, 2011, it is not necessary to submit a request to exceed the 129 hours per month of habilitation. All Continued Need Reviews (CNRs) that exceed 129 hours a month of habilitation services that meet Medical Necessity will be approved through October 31, 2011, and the new limit for adults will go into effect November 1, 2011. CNRs which include more than 129 hours will need to be revised effective November 1, 2011 or a request to exceed the limit for children under age 21 must be submitted. Requests to exceed 129 hours per month for children under 21 years of age after November 1, 2011 will be reviewed under EPSDT and if denied, the recipient will be provided with appeal rights.

Effective November 1, 2011, No More Than 129 hours of Habilitation per Month

Effective November 1, 2011, the total habilitation hours received by a participant must not exceed 129 hours of habilitation per month. Please review the CAP MR/DD services that are available. The 129 hours per month

limit is inclusive of the habilitation the participant may receive through engagement in Day Supports, Supported Employment, Long Term Vocational Supports and Home and Community Supports. *NOTE: The combination or distinct utilization of these services is not to exceed 129 hours a month.*

The 129 hours a month is not viewed as an average yearly amount. **The 129 hour per month limitation does NOT include habilitation hours provided in Residential Supports and/or Home Supports.** (Please see next section for more detail.)

Residential Supports and Home Support Services (direct contact hour requirements)

Due to the number of individuals who will be affected by the implementation of the Utilization Review Criteria posted in Implementation Update #76 on July 7, 2010, a decision has been made to extend the transition period specific to Residential Supports and Home Support services (direct contact hour requirements) to October 31, 2011. This extension serves to ensure there is no interruption in services.

Utilization Review

All CAP MR/DD service requests as of May 30, 2011 will be reviewed according to the Utilization Review Criteria set forth in Clinical Coverage Policy No. 8M.

New Waiver Effective November 1, 2011

The new waiver, effective November 1, 2011, allows for a **maximum total of 129 hours** of habilitation per month. This includes Days Supports, Supported Employment, Long Term Vocational Support and Home and Community Supports. **This is a firm limit FOR ADULTS over age 21. Requests to exceed the limit for children under age 21 will be reviewed under EPSDT.**

All requests authorized prior to October 31, 2011 that exceed the Utilization Criteria for habilitation will need to be in compliance by November 1, 2011. Because of the quantity of revisions that will be submitted, it is strongly recommended that services are transitioned prior to October, 31 2011 or at least 15 business days prior to the effective date of the request to allow the UR vendors ample time to complete the authorizations.

Billing of more than 129 hours a month of habilitation will result in denial of units above the maximum allowable regardless of prior approval, unless more units have been approved for a child under EPSDT.

Due Process

As of November 1, 2011 the 129 hours a month of habilitation will be a limitation for adults and therefore it cannot be appealed for recipients 21 and over. Requests submitted for recipients under the age of 21 will be reviewed under EPSDT and if denied, the recipient will be provided with an adverse decision notice that includes an appeal form and a description of how to appeal to the Office of Administrative Hearings.

Reminder

As stated in Implementation Update #78, when submitting CAP MR/DD revision or provider change requests for CNRs that have been approved by ValueOptions, the targeted case managers are required to submit the following documents:

1. A complete revision request including CTCM forms, cost summary and signature page, as well as any other documentation required per service definitions.
2. A complete copy of the last CNR packet including cost summary, signature page and MR2.
3. Copies of any revisions that were approved by ValueOptions after the last CNR and prior to the revision being requested.

If the targeted case manager has not needed to submit a revision or provider change to the new UR vendor, please include the last approved CNR packet and copies of any revisions that were approved by ValueOptions when the annual CNR is submitted to the appropriate UR vendor.

CAP-MR/DD Waiver Slots and MFP Slots Update

Because of budgetary issues all CAP-MR/DD Comprehensive and Support Waiver slots have been frozen. This includes emergency slots, and deinstitutionalization (DI) slots. Slots allowing individuals to transfer from the Supports Waiver to the Comprehensive Waiver have also been frozen.

Despite current budget restraints, we have been fortunate to support 30 people with Money Follows the Person (MFP) CAP-MR/DD slots as they transition into their communities. All 30 MFP CAP I/DD slots for this year have been allocated. No additional MFP slots will be available during this waiver year.

Guidance for Electronic Signatures

Electronic Signatures

Per HIPAA standards, an electronic signature means the attribute affixed to an electronic document to bind it to a particular party. An electronic signature secures the user authentication (proof of claimed identity) at the time the signature is generated; creates the logical manifestation of signature (including the possibility for multiple parties to sign a document and have the order of application recognized and proven); supplies additional information such as time stamp and signature purpose specific to that user; and ensures the integrity of the signed document to enable transportability of data, interoperability, independent verifiability, and continuity of signature capability. Verifying a signature on a document verifies the integrity of the document and associated attributes and verifies the identity of the signer. If an entity uses electronic signatures, the signature method must assure all of the following features: message integrity (evidence that the document has not been altered); nonrepudiation (strong and substantial evidence that will make it difficult for the signer to claim that the electronic representation is not valid), and user authentication (evidence of the identity of the person signing). No specific technology is mandated by HIPAA.

Authenticated/Dated Signatures

There are some instances where a person's signature is critical to the authenticity of a document, whether it is the signature of the service provider, the individual, the legally responsible person, or other individual. In situations when a dated signature is required, as in the case of service orders, person-centered plans, or service plans, etc., the signature is authenticated when the person enters the date next to his or her signature. A handwritten signature requires a handwritten date, and an electronic signature shall include a time and date stamp. In either case, entering the date at the time that the signature is written confirms that the signature was made on that date. The date entered is always the date that the person signs the document. The practice of pre- or post-dating signatures in any form or circumstance is prohibited. As previously discussed in the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services Records Management and Documentation Manual, for late entries, a dated signature is indicated. When entering corrections in the service record, the staff's initials and date that the correction was made are required.

Electronic Signatures of Staff

For purposes of this policy, the use of the word, "staff" is inclusive of the employees of a governing body, owner(s), individuals under contract with a provider agency, or individual behavioral health practitioners in a private practice.

When an electronic signature is entered into the electronic record by agency staff (employees or authorized individuals under contract with the agency), the following standards shall be followed:

1. When an electronic signature is used, the provider shall be given an opportunity to review the entry for completeness and accuracy prior to electronically signing the entry.
2. Once an entry has been signed electronically, the computer system shall prevent the entry from being deleted or altered. The entry shall include a time and date stamp.
3. If errors are later found in the entry, or if information must be added, this shall be done by means of an addendum to the original entry. The addendum shall be signed electronically and shall include a time and date stamp.
4. Passwords or other personal identifiers shall be controlled to ensure that only the authorized individual can apply a specific electronic signature. Passwords should be changed at specified intervals.
5. Any staff authorized to use electronic signatures shall be required to sign a statement that acknowledges their responsibility and accountability for the use of their electronic signature. The statement must explicitly state that the provider is the only one who has access to and use of this specific signature code/password.
6. An electronic signature shall be under the sole control of the person using it. A provider shall not delegate their electronic signature authorization to another person.

7. Policies and procedures shall be developed to:
 - a. Safeguard against unauthorized use of electronic signatures. The policy shall also address sanctions for improper or unauthorized use of electronic signatures.
 - b. Address procedures that staff should follow if the application is unavailable.
 - c. Address procedures when a staff member is not available to electronically sign documents.
8. The governing body shall authorize the use of electronic signatures, and a list of all current staff who are authorized to use electronic signatures shall be maintained and kept on file.

If an agency has a governing body, authorization and compliance to this policy shall be documented in the governing body minutes, and the governing body chairperson shall sign and date the authorized list, which should be maintained by the executive director (or designee) of the organization and the designated medical records staff person. In addition, a letter of authorization shall be placed in each staff member's personnel file.

If the agency does not have a governing body, then the executive director or designee, along with the medical records staff person or office manager, shall document compliance to this policy and the authorization of staff to use electronic signatures, in an administrative meeting or supervision. In addition, a letter of authorization shall be placed in each staff member's personnel file.

Evidence of compliance with this policy would be supported by a notarized statement of compliance, maintained by the staff indicated above, as well as filing a letter of authorization in each staff member's personnel file, with the approval date; agreement for use, and other relevant information.

NOTE: The above electronic signature standards are subject to revision based upon state law and/or HIPAA requirements.

Electronic Signatures of Recipients, Legally Responsible Persons, and Others

The following protocol is specific to electronic signatures obtained from service recipients, parents, legally responsible persons, representatives from other agencies, and other individuals who are not agency staff. This guidance applies when an agency is seeking any non-agency signature(s) on documents such as person-centered plans, service plans, release of information forms, consent forms, etc.

In all cases, the person whose signature is being sought shall be given ample opportunity to review the document for completeness and accuracy prior to electronically signing the document.

When obtaining electronic signatures of individuals receiving services, legally responsible persons, representatives from other agencies, and others, the only acceptable format is a digitized signature - an electronic image of an individual's handwritten signature reproduced in its identical form using a pen tablet. The signature(s) must include a time and date stamp, and the signature must be entered on the electronic image of the document that they are signing.

Once an entry has been signed electronically, the computer system shall prevent the entry from being deleted or altered. The entry shall include a time and date stamp.

If errors are later found in the entry, or if information must be added, this shall be done by means of an addendum to the original entry. The addendum shall be signed electronically and include a time and date stamp.

Fraudulent Trends in Outpatient Services

Program Integrity has identified some trends in outpatient mental health non-physician practices, independent and group. Some providers are operating after-school programs, summer programs, or non-licensed day treatment programs and submitting claims for reimbursement from the North Carolina Medicaid Program. Medicaid only reimburse for services that are medically necessary when the provider is qualified to provide the services.

Recently, one provider who received a federal indictment operated an afterschool tutorial program. Michael Shawn Brown, a Columbus County School counselor and an outpatient mental health provider licensed as a Professional Counselor has been indicted on charges of wire fraud, identity theft, and arson by the U.S.

Attorney's Office. He allegedly provided free teacher-supervised tutoring services, snacks and transportation to children of lower-income families.

Mr. Brown allegedly had his employees obtain copies of each recipient's Medicaid card. He is suspected of submitting false claims for therapy sessions to his billing agent in Florida for reimbursement from the North Carolina Medicaid program.

Mr. Brown's business also burned down one night before he was scheduled to meet with investigators. Currently, Mr. Brown is charged with twenty counts of wire fraud, two counts of aggravated identity theft, two counts of arson and one count of making material false statements.

Providers should know that defrauding the NC Medicaid program is a serious offense and will be dealt with accordingly. Sometimes the penalty includes civil and/or criminal remedies.

Reporting Provider Fraud and Abuse

The N.C. Department of Health and Human Services has created a poster, <http://www.ncdhhs.gov/dma/fraud/FraudPoster.pdf>, asking citizens to report Medicaid fraud and abuse. In a memo, <http://www.ncdhhs.gov/dma/fraud/FraudMemo.pdf>, dated June 4, 2010, Department of Health and Human Service (DHHS) Secretary Lanier Cansler asked all health care agencies and private health care providers to print and prominently display the poster in their offices.

You are encouraged to report matters involving Medicaid fraud and abuse. If you want to report fraud or abuse, you can remain anonymous; however, sometimes in order to conduct an effective investigation, staff may need to contact you. Your name will not be shared with anyone investigated. (In rare cases involving legal proceedings, we may have to reveal who you are.)

First Commitment Update

The General Assembly, via Senate Bill 437, extended the authority of the Secretary to waive the requirement that a first commitment examination be completed by a physician or eligible psychologist to allow licensed clinical social workers, master's level psychiatric nurses, or master's level certified clinical addictions specialists (LCAS) to also perform such examinations. In the case of LCASs, they will only be authorized to conduct the initial examination of individuals meeting the criteria of G.S. 122C-281(a).

This legislation will not be construed as authorization to expand the scope of practice of the licensed clinical social worker, the master's level psychiatric nurse, or the master's level certified clinical addictions specialist. All individuals performing first examinations under the waiver must successfully complete the DHHS standardized training program, examination and certification process. The names of those successfully completing the process will be maintained on the DMH/DD/SAS website. Participating LMEs shall document the availability of a physician to provide backup support. DMH/DD/SAS will expand its standardized certification training program to include refresher training for all certified providers performing initial examinations with more information to be forthcoming.

A waiver granted by the Secretary under this legislation shall be in effect for a period of up to three years and may be rescinded at any time within this period. Applying LMEs shall propose the following to the Secretary:

1. How the purpose of the statutory requirement would be better served by waiving the requirement and substituting the proposed change under the waiver.
2. How the waiver will enable the LME to improve the delivery or management of mental health, developmental disabilities, and substance abuse services.
3. How the health, safety, and welfare of individuals will continue to be at least as well protected under the waiver as under the statutory requirement.

The Secretary shall review the request and may approve it upon finding all of the following:

1. The request meets the requirements of this section.
2. The request furthers the purposes of State policy under G.S. 122C-2 and mental health, developmental disabilities, and substance abuse services reform.

3. The request improves the delivery of mental health, developmental disabilities, and substance abuse services in the counties affected by the waiver and also protects the health, safety, and welfare of individuals receiving these services.

LMEs which have heretofore applied and been approved (18 of the current 23 LMEs have applied and been approved to perform first examinations) will have until October 1, 2014 to exercise this waiver. If they wish to continue, they will need to reapply prior to this date.

CABHA Key Staff Changes

Changes regarding the three key staff positions within a CABHA (Medical Director, Clinical Director, and Quality Management/Training Director) must be submitted by hard copy using trackable mail. If an email is sent with attached documents, a hard copy is still required to be sent by trackable mail. In the event that the provider has obtained a resignation letter from the Clinical Director or Medical Director a copy of the resignation letter must also be submitted with the change information.

Unless noted otherwise, please email any questions related to this Implementation Update to ContactDMH@dhhs.nc.gov.

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