Administrative Requirements

ASAM Designation from MDHHS

All contracted SUD provider agencies must apply for and obtain MDHHS approval for each ASAM level of care they plan to provide under the MCCMH-SUD contract. ASAM levels must be renewed in a timely manner to ensure compliance.

PIHP staff will open an ASAM application for your agency in the MiLOGIN system.

The main contact person for your agency will receive notification to complete the application. Applications are then submitted to MDHHS for review/approval.

CHAMPS Enrollment

All providers who serve Michigan Medicaid beneficiaries must be screened and enrolled in the Community Health Automated Medicaid Processing System (CHAMPS). For assistance in enrolling, please call 1-800-292-2550 option 4.

MDHHS uses provider email addresses entered in the CHAMPS provider enrollment application to communicate with providers.

Providers are responsible for maintaining accurate and valid email address information within their CHAMPS provider enrollment information. If the email address information is outdated or incorrect, enrolled providers should update their enrollment information and submit it for approval.

All providers must enroll in the CHAMPS system in order to receive payment from MCCMH.

SAMHSA Registration for OTPs

All Opioid Treatment Provider (OTP) agencies must register with SAMHSA via extranet and update registration as necessary.

MCCMH-SUD will request copies of these registration certificates to ensure compliance.

Registration applications can be completed at: OTP Extranet System

Adding New Staff

- When a new staff member is hired to see MCCMH-SUD-funded clients, the program must first ensure that they meet the credentialing requirements of the MCCMH-SUD contract.
- The supervisor would send a Director's Verification form to MCCMH-SUD for review/approval. These can be submitted to mcosa@mccmh.net along with the supplemental documentation.
- Any staff requiring FOCUS access should have a request form completed and submitted by their supervisor. These can be submitted to mcosa@mccmh.net.
- Staff cannot provide services to MCCMH-SUD-funded clients until they have an approved Director's Verification Form on file.
- Providers must complete an initial credentialing review and re-credential staff every two years.
- Staff must complete required training within 90 days of hire and every two years to align with re-credentialing.
- Staff must maintain any licenses/certifications required to provide services per MDHHS staff credentialing rules.

SUD Required Trainings

All MCCMH-SUD Required Trainings can be found at www.mccmh.net in the Substance Use Provider Manual

Training	Location Offered	Requiring Agency	Timeframes for Completion	Required Staff
SUD Communicable Disease-Level 1	Improving MI Practices	MDHHS	Within 90 days of hire and every two years	All staff
Corporate Compliance	Internal Training	MDHHS	Within 90 days of hire and annually	All staff
MCCMH Grievance and Appeals	Brainier	MDHHS	Within 90 days of hire and every two years	All staff
New Employee Orientation	Internal Training	MDHHS	Within 90 days of hire	All staff
Cultural Diversity	Brainier	MDHHS	Within 90 days of hire and every two years	All staff
SUD Basics of Confidentiality	Improving MI Practices	MDHHS	Within 90 days of hire and every two years	All staff
MCCMH Limited English Proficiency	Brainier	MDHHS	Within 90 days of hire and every two years	All staff
SUD Recipient Rights	Improving MI Practices	MDHHS	Within 90 days of hire and every two years	All staff
Assessing and Managing Suicide Risk (AMSR)**	Brainier	MCCMH	Within 90 days of hire and every two years	Clinical staff only
Question, Persuade, Refer (QPR)**	Brainier	MCCMH	Within 90 days of hire and every two years	Non-clinical staff
MATE Act Training on Treatment and management of OUD and other SUD	SAMHSA/DEA Approved Provider	MDHHS	Prior to prescribing MOUD at an OTP	SOR funded OTP prescribing providers

MCCMH-SUD DIRECTOR'S VERIFICATION OF STAFF CREDENTIALS

Staff Name:_____ Title/Position:_____
Agency Name:_____ Site:_____
Requested Effective Date:_____

TYPE OF CREDENTIALING (check all that apply):

- ☐ **Substance Use Disorder Treatment Specialist - *Master's Licensed, Limited Licensed, Temporary Licensed* Individual**
  - ☐ Social Worker, Psychologist, Marriage & Family Therapist, Professional Counselor, ***and***
    - ☐ MCBAP Certified or,
    - ☐ MCBAP Development Plan
- ☐ **Substance Use Disorder Treatment Practitioner - *Non-Master's licensed* Individual (not eligible for reimbursement of psychotherapy services)**
  - ☐ Non-Licensed Individual, or
  - ☐ License or Limited Licensed Bachelor's Social Worker, ***and***
    - ☐ MCBAP Certified or,
    - ☐ MCBAP Development Plan
- ☐ **Clinical Supervisor - *Licensed, Limited Licensed, Temporary Licensed* Individual**
  - ☐ Social Worker, Psychologist, Marriage and Family Therapist, ***and***
    - ☐ MCBAP Certified Clinical Supervisor or,
    - ☐ MCBAP Development Plan Certified Clinical Supervisor
- ☐ **Substance Use Disorder Prevention Specialist/Consultant**
  - ☐ Certified Prevention Specialist, or
  - ☐ Certified Prevention Consultant, or
  - ☐ MCBAP Development Plan
- ☐ **Substance Use Disorder Prevention Specialty Focused Staff**
  - ☐ Providing one specific service under a certified supervisor
- ☐ **Peer Recovery Coach (Outpatient Only)**
  - ☐ MDHHS Certified Peer Recovery Coach
- ☐ **Medical Staff**
  - ☐ Physician, Psychiatrist, Physician Assistant, Nurse Practitioner, Registered Nurse, Licensed Practical Nurse
  - ☐ EMT
- ☐ **SUDHH Only**
  - ☐ Community Health Worker
  - ☐ Peer Recovery Coach
    - ☐ MDHHS Certified
    - ☐ CCAR Trained
    - ☐ MCBAP Development Plan and/or Credential
  - ☐ Behavioral Health Specialist (Licensed or Limited Licensed Bachelor's or Master's Level Social Worker, Licensed Marriage & Family Therapist, Licensed Professional Counselor, or Licensed Psychologist)

Application must be submitted and approved prior to the provision of direct service, or services may not be reimbursed. Documentation must be submitted for all items checked above (attach copy of License and/or Certification).

- ☐ Requesting FOCUS Login ID and password (attach FOCUS Access Request Form)
- ☐ Requesting ASAM permission (attach training Certificate)
- ☐ Requesting GAIN permission (attach training Certificate)

I attest that Communicable Disease, Substance Use Recipient Rights, Confidentiality, and other required training has/will be completed within 30 days of hire.

The undersigned attests to the personal possession of, and the authenticity and validity of the above-described license, credential or equivalent and training, and are in good standing.

_____ _____
Staff Member's Signature Date

The undersigned attests that the above-described license, credential or equivalent, and training, has been verified as being possessed and in good standing by the staff person named above. The program has/will complete all staff qualification requirements, including criminal background check, completed credentialing/recredentialing, and/or privileging requirements, obtained direct source verification, and has this information available at the SUD Department's request.

_____ _____
Program Director's Signature Date

_____
PRINT Program Director's Name

SUD Department Use Only

Packet received on:_____
Information Complete? ☐ Yes ☐ No If no, list missing information requested:_____
Date additional information received:_____

OIG/MDHHS Sanctioned provider check ☐ Yes ☐ n/a
Information provided supports Credentialing: ☐ Yes, for:
☐ Substance Abuse Treatment Specialist ☐ Substance Abuse Treatment Practitioner
☐ Clinical Supervisor ☐ Substance Abuse Prevention Specialist/Consultant
☐ Substance Abuse Prevention Specialty Focused Staff ☐ Peer Recovery Coach
☐ Medical Staff ☐ SUDHH Only Staff
☐ No/Denied, due to _____

Authorization Effective Date:_____
SUD Department Signature: _____ Signature Date:_____
Response sent to provider on: _____

MACOMB COUNTY CMH – SUBSTANCE USE DEPARTMENT
FOCUS SOFTWARE SYSTEM ACCESS REQUEST

☐ **Enrollment** (new staff; add *new/additional* location)
☐ **Disenrollment** (remove staff) – must provide last date of employment.
☐ **Change** (*change* locations, function, license) – must indicate the change in section D.

A. System Access Requested For:

First Name:	Last Name:	
Email Address:	Phone:	Fax:
Job Title:	Date of Hire:	Date of Disenrollment:

B. Functions: Please place an "X" in the appropriate box(es) as applicable (you must select at least one):

☐ Claims Mgmt. staff
☐ Clerical staff
☐ Recovery Home
☐ SUDHH staff
☐ SUDHH **(without User ID)**
☐ Peer Coach
☐ Peer Coach **(without User ID)**
☐ Intern (must have LMSW as Supervisor)
Supervisor name: _____
☐ Intern **(without need for User ID)**
Supervisor name: _____
☐ Clinical/Medical **(without User ID)**
☐ Clinical/Medical staff
☐ Clinical with ASAM permission*
☐ Clinical with GAIN permission*
**must include Certificate of Completion*

Agency Name & All Site Locations You Are Requesting Access For:

C. Clinical/Medical Staff ONLY

Highest Degree:	**Graduation Date (Month/Date/Year):**
State of MI License(s) – name and number, Issue Date and Expiration Date(s): Clinical staff without a license must report years of post-degree experience.	
NPI number (if applicable):	**DEA number (Physicians only)**
SUD Credential and/or MCBAP Development Plan:	**Expiration Date(s) (Month/Date/Year):**

D. The responsible supervisor MUST notify MCCMH-SUD immediately when a staff person's FOCUS profile needs updating/ended. These updates include the following:

Change in Employment Status:
☐ Termination/Resignation
☐ Transfer of Location
☐ Change in Staff Role (from/to_____)

Contact Updates:
☐ E-mail
☐ License/MCBAP status change/Expiration
☐ Name Change (include previous name) _____

Requestor/Supervisor Name:

Title:	**Phone:**	**Email:**

My Signature attests that all information above is accurate and complete to the best of my knowledge.

Signature: **Date:**

SUD: Please submit form to mcosa@mccmh.net. ***ALL REQUESTS MUST BE IN WRITING!***