EXHIBIT D

CREDENTIALING AND RE-CREDENTIALING REQUIREMENTS

The Michigan Department of Health and Human Services, Behavioral Health and Developmental Disabilities Administration, has issued a uniform Credentialing and Re-credentialing Policy applicable to all individual and organizational providers directly or contractually employed by Pre-Paid Inpatient Health Plans (PIHP's), as it pertains to the rendering of specialty behavioral healthcare services within Michigan's Medicaid Program. PIHPs and CMHSPs are responsible for ensuring that each provider, directly or contractually employed, meets all applicable licensing, scope of practice, contractual and Medicaid Provider Manual Requirements.

1. Providers that employ or contract with the following health care professionals are required to have a written system (policy and procedure) in place for the credentialing and re-credentialing of these individuals.

- Physicians (M.D.s and D.O.s)
- Physician's Assistants
- Psychologists (Licensed, Limited License, and Temporary License)
- Social Workers:
    - Licensed Master's Social Workers
    - Licensed Bachelor's Social Workers
    - Limited License Social Workers
    - Registered Social Service Technicians
- Licensed Professional Counselors and Limited License Professional Counselors
- Nurse Practitioners, Registered Nurses and/or Licensed Practical Nurses
- Occupational Therapists and Occupational Therapist Assistants
- Physical Therapists and Physical Therapist Assistants
- Speech Pathologists
- Registered Dieticians

2. Required Components of Credentialing Policy: The Providers' policies and procedures for credentialing and re-credentialing of health care professionals must include the following elements:
    a. Scope, criteria and timeliness, and the process for credentialing and re-credentialing providers.
    b. Identification of the administrative staff person that is responsible for oversight and implementation of the process, and delineation of their role.
    c. A description of the role, if any, of participating providers in making credentialing decisions.
    d. Provisions for Temporary and/or Provisional Privileging of Individual Providers. At a minimum, these standards include the following:
        i. Temporary status may be granted for not more than 120 days.
        ii. Provisional status may be granted for not more than one (1) year.
        iii. At a minimum, the provider must complete, date and sign an application that includes the following elements:
            1. Lack of present illegal drug use;
            2. Identification of and an explanation about any history of loss of license, registration, or certification, and/or felony convictions;
            3. Identification of and an explanation about any history of loss or limitation of privileges or disciplinary actions;
            4. A summary of the provider's work history for the past five years;
            5. Attestation by the applicant of the correctness and completeness of the application.
        iv. Primary source verification of:
            1. Licensure or certification;
            2. Board Certification, if applicable, or highest level of credential attained; and
            3. Medicare/Medicaid sanctions.
    e. The standards to be used in making a credentialing and/or re-credentialing decision. At a minimum, these standards include the following:

i. A written application, completed, signed and dated by the health care professional, that attests to the following elements:
    1. Lack of present illegal drug use;
    2. Identification of and an explanation about any history of loss of license and/or felony convictions;
    3. Identification of and an explanation about any history of loss or limitation of privileges or disciplinary actions;
    4. Attestation by the applicant of the correctness and completeness of the application.
ii. An evaluation of the health care provider's work history for at least the prior five years.
iii. Primary source verification of:
    1. Licensure or Certification
    2. Board Certification (if applicable) or highest level of credentials attained, or completion of any required internships, residency programs or other post graduate training
    3. Documentation of graduation from an accredited school
    4. National Practitioner Databank (NPDB)/Healthcare Integrity and Protection Databank (HIPDB) query or, in lieu of the NPDB/HIPDB query, all of the following must be verified:
        a. Minimum of five-year history of professional liability claims resulting in a judgment or settlement;
        b. Disciplinary status with regulatory board or agency; and
        c. Medicare/Medicaid Sanctions.
    5. If the individual practitioner undergoing credentialing is a physician, then physician profile information obtained from the American Medical Association or American Osteopathic Association may be used to satisfy the primary source requirements of 1, 2, and 3 above.

f. A description of the documents and methodology to be used by the provider organization to determine that a credentialing file is complete.
g. The role of a credentialing committee and criteria for credentialing health care providers, including the role of the governing authority in making credentialing decisions.
h. Requirements for re-credentialing include, at a minimum, the following:
    i. Re-credentialing at least every two years;
    ii. An update to the information obtained during the initial credentialing;
    iii. A process for on-going monitoring, and intervention if appropriate, of provider sanctions, complaints and quality issues which must include, at a minimum, review of:
        1. Medicare/Medicaid Sanctions;
        2. State sanctions or limitations on licensure, registration or certification;
        3. Member (i.e., "consumer") concerns which include grievances and appeals information;
        4. Quality issues.
        5. Recipient Rights check
i. Provisions of the communication of all credentialing and/or privileging decisions, in writing, to applicants for credentialing or re-credentialing.
j. Provisions for appeal of privileging, credentialing and/or re-credentialing decisions.
k. Approval of the policy and/or procedure by the provider's governing authority.

3. Providers are prohibited from discriminating against:
    a. a health care professional (defined above) solely on the basis of license, registration or certification; or
    b. a health care professional who serves high risk populations or who specializes in the treatment of conditions that require costly treatment.

4. Providers must ensure compliance with Federal Requirements that prohibit employment of or contracts with individuals who are excluded from participation under either the Medicare or Medicaid programs. Proof that individuals are not sanctioned or excluded from federal healthcare program participation must be maintained. A complete list of Centers for Medicare and Medicaid Services (CMS) sanctioned providers is available at http://exclusions.oig.hhs.gov. A complete list of sanctioned providers is also available on the MDHHS website at http://www.michigan.gov/mdhhs.

5. The provider must maintain an individual credentialing/re-credentialing file for each covered health care professional. Each file must include, at a minimum:

a. The initial credentialing and all subsequent re-credentialing applications;
b. Documented evidence of primary source verification; and
c. Any other pertinent information the provider used in determining whether or not the provider met the credentialing and re-credentialing standards.

6. The PIHP reserves the following rights:

    a. To Approve, Suspend or Terminate from participation in the provision of Medicaid funded services any individual health care provider or health care provider organization;
    b. To provide oversight regarding all credentialing and re-credentialing decisions.
    c. To extend "deemed status" to organizations and/or individuals who are credentialed by other PIHPs provided that copies of the other PIHP's credentialing files are submitted.
    d. To credential and re-credential, at least every two years, organizational providers in its network through the validation and re-validation:
        i. That the organizational provider is licensed or certified (as necessary) to operate in Michigan, and that the organization has not been excluded from Medicaid or Medicare participation;
        ii. Ensure that contracts require organizational providers to credential and/or re-credential their direct employed and sub-contacted direct service personnel in accordance with this attachment.
    e. To verify compliance with these requirements the PIHP may:
        i. Require the provider to submit credentials files to it for review and validation;
        ii. Confirm the credentialing and re-credentialing activity of the organization during scheduled or non-scheduled site reviews by authorized PIHP representatives;
        iii. Pursue other reasonable actions to ensure compliance.

7. Providers are responsible for ensuring that direct employed and/or contractual health care professionals meet the minimum qualifications for the delivery of health care services.
    ~~a.~~ Minimum qualifications are specified for Medicaid covered services in the MDHHS Provider Qualifications document, accessible at **https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html**
    b. Development Plans must include prompt and reasonable timeframes for completion.