UPHP
UPPER PENINSULA HEALTH PLAN

CSHCS Physician Attestation

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Children's Special Health Care Services (CSHCS) primary care providers (PCPs) supervise, coordinate, and provide primary care, initiate referrals for specialty care, maintain continuity of CSHCS enrollee's health care, and maintain the CSHCS enrollee's medical record. Each CSHCS PCP must attest in writing that they meet specific qualifications. CSHCS PCPs receive additional payment for care coordination services as shown:

- $4.00 per enrollee per month for each assigned TANF CSHCS enrollee
- $6.00 per enrollee per month for each assigned HMP CSHCS enrollee
- $8.00 per enrollee per month for each assigned ABAD CSHCS enrollee

To receive additional payment, services must be rendered at a patient centered medical home (PCMH) and UPHP must obtain written consent that specifies the PCP and practice:

- Are willing to accept new CSHCS Enrollees with potentially complex health conditions.
- Regularly serve children or youth with complex chronic health conditions.
- Have a mechanism to identify children/youth with chronic health conditions.
- Provide expanded appointments when children have complex needs and require more time.
- Have experience coordinating care for children who see multiple professionals (pediatric subspecialists, physical therapists, behavioral health professionals, etc.).
- Have a designated professional responsible for care coordination for children who see multiple professionals.
- Provide services appropriate for Health Care Transition, including but not limited to the use of a transition assessment tool and adoption of a transition policy that is publicly posted and specifies the transition time frame, transition approach and legal changes that take place in privacy and consent at age 18.

Please select the option below that applies to you and return this form via email to uphpproviderrelations@uphp.com. If none of these options apply, you need not return attestation. Payment is made to the medical group on a quarterly basis.

☐ I am an individual physician rendering services at a PCMH designated Medical Group and attest I meet all qualifications and will act as a CSHCS PCP.

☐ I am an authorized representative of this PCMH designated Medical Group, and I acknowledge and agree all physicians will act as a CSHCS PCP and meet all qualifications.

☐ I am an authorized representative of this PCMH designated Medical Group. I acknowledge and agree the following physicians will act as a CSHCS PCP and meet all qualifications:

_____

_____

Medical Group: _____ Service Location NPI: _____

Print Name: _____ Date: _____

Signature: _____

Please call UPHP Provider Relations with any questions at 906-226-4285.