CalAIM: Enhanced Care Management (ECM) Frequently Asked Questions

March 10, 2022

What are the four components required to consider a successful ECM engagement?

a. engaged with the member in-person or telephonically, and
b. the member has agreed to be enrolled in ECM, and
c. the member has signed an ROI, and
d. the ECM Lead Care Manager has started and/or completed the required Individualized Care Plan

What is an outreach attempt?
An outreach attempt is an interaction with a referred member/ patient that is NOT enrolled yet.

Does "outreach" occur with referred patients?
Yes

Does "outreach" occur with enrolled patients?
No

Are successful outreach attempts to referred members reported on the RTF?
You are welcome to track the count for referred members on the RTF, but you'll keep track of your successful outreach attempts on the IOT for referred members they have not been enrolled.

Are unsuccessful "outreach" attempts to referred member reported on the RTF?
No, this is already accounted for on the IOT.

Are unsuccessful "encounter" attempts reported on the RTF for enrolled members?
No, DHCS is not interested in documenting any unsuccessful encounters for enrolled members at this time.

Referrals:

What is discussed by PHC when doing the assessment call?
General education about the ECM benefit, then questions assessing for eligibility for the Populations of Focus and any exclusion criteria that may apply.

Does PHC discuss the ECM program and what to expect?
Yes

Does PHC let the member know which ECM Provider they are referring the member to and that we will be contacting the member?
Yes, however provider referral and assignment occurs after the call is ended. Once the ECM team receives the case, we determine eligibility and then assign if the member is eligible. The member will receive a letter in the mail welcoming them to ECM Benefit and it has their referred/ assigned provider listed at the bottom with a phone number to call and reach out.

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February 24, 2022

What is the responsibility as far as outreach notes in Collective Medical?
You are responsible for updating encounters with the member. You can use your own case notation system but we do not require you to update the encounter in Collective Medical. We recommend that you update the care plan continuously.

Do we need to fill out the referral form for all patients?
No, a referral form is not necessary for every member. It can be used if you are unsure if the member qualifies using DHCS criteria to receive the ECM benefit and you'd like PHC to investigate further. If you are able to engage with the member, get a signed ROI and develop a care plan you may submit with the TAR and skip the referral step.

Will there be a negative outcome if we are unable to outreach to a non-established patient referral?
If you are unable to accept the member as a referral, let us know on the Return Transmission File (RTF) and we will refer the member to another provider.

If we identify a patient that may qualify and we submit a TAR, does PHC verify if they are not already enrolled in another ECM program?
Yes, PHC will verify if they are enrolled in another ECM program.

If a patient is a PHC member, can we presume they are eligible for ECM benefits?
Members on the Targeted Engagement List (TEL) have been screened for ECM and are potentially eligible for the ECM benefits. Because overall Medi-Cal eligibility can fluctuate, we would ask the ECM provider to verify PHC eligibility prior to outreach and engagement.

Why is it necessary to report the number of hospital visits?
PHC reports this to the ECM Provider on the Member Information File (MIF), it is not required of the ECM Provider to report this back to PHC

How often is the Target Engagement List (TEL) uploaded and sent to Collective Medical?
At this time, the Target Engagement List is uploaded once a month during the first week of the month. We are discussing updating this more frequently later down the road.

If we receive a referral from PHC, do we need to complete a TAR for the referral?
Yes, a TAR is based upon a completed and signed ROI and care plan. It is up to the provider to submit the TAR and engage with the member when the referral is received.

If we receive a referral from PHC, has the member's eligibility already been verified?
Yes, the members are vetted before a referral is sent to the provider. However, because overall Medi-Cal eligibility can fluctuate, we would ask the ECM provider to verify PHC eligibility prior to outreach and engagement.

How are per member per month (PMPM) payments reimbursed if we are sending electronic claims?

Claims will be paid the same as normal claims with a remittance advice and physical check. If you already receive payment electronically then you will receive an EFT.

For high utilizer or mental health disorder, what codes should they use?
Use a code that is applicable to what you are servicing the member for. DHCS has not provided ECM specific codes for high utilizers and/or SMI/SUD as there are quite a bit of ICD-10s, and the code/codes are dependent on the member's condition(s).

Do we have to submit a claim per day/unit for failed and successful outreach to reflect IOT file? Does the IOT file replace that?
All outreach attempts need to be submitted on claims. Submit the total units per day with corresponding code/modifier.

February 15, 2022

What date should be used for the production date for the Return Transmission File (RTF)?
The production date will be the last date you fill out the file or produce the data into the file.

How can I refer a member moving to a different county to another ECM provider for continuation of support?
The Return Transition File (RTF) and ECM member referral file that can be used to document to PHC.

The RTF File has two areas to report the number of contacts whether face-to-face or telephonic. Are we entering the number of contacts directly with the client or are any contacts with care coordination? Connecting with facility on behalf of member counts?
The columns for tracking number of encounters are specific to encounters with the member and not on behalf of the member. DHCS is only interested in how many times you've engaged with the member at this time.

Members who transition from Whole Person Care (WPC) who are refusing to sign ROI and taking us longer, are we going to be able to keep them enrolled? What can our team do?
Currently in review.

Will our referrals be for patients who are already established at the clinic or will PHC also refer non-established patients?
We look at several factors such as the member's population of focus, the provider's population of focus expertise/experience, member's preference, proximity to member, and the provider's capacity.

Is there any circumstance where a wet signature consent is not required?
DHCS requires a wet signature.

How in-depth do the care plans have to be?
The care plan needs to follow the DHCS guidelines and should be based on the member's health

status, needs, preferences, and goals regarding physical health, mental health, disabilities, substance use, oral health, community-based long-term services and supports, supports to manage serious illness, trauma-informed care needs and community and social services.

Do Medi-Cal patients need to be a PHC member in order to receive PHC's ECM services?
Yes

On the ROI, what is attachment A?
The attachment A, is created by the ECM provider and lists entities you are contracted to share information.

On the IOT file, does every successful and unsuccessful attempts need to be documented?
Each attempt should be documented on each line.

In the RTF, encounters column includes only successful contact with member or also includes unsuccessful?
On the RTF, Columns U and V are to capture successful contacts with the member, either via in-person or telephonic/electronic. DHCS is not interested at documenting any unsuccessful encounters for enrolled members at this time.

February 3, 2022

If we talk to a patient's primary caregiver (ex mother), does that count as a monthly encounter?
Yes, as long as the primary care giver is the Authorized Representative (AR) and you are addressing the member's ECM needs.

For clients that are automatically enrolled/transferring over to this program and do not require a TAR for enrollment: Do they have an authorization number in the system as they would for a TAR?
Yes, you will receive an approval letter once it is inputted into the system.

How do we submit the Care Plan – is that through the TAR portal?
For the grandfathered members, PHC requires you to load the care plan in Collective Medical. For new members, you will also need to upload into Collective Medical and submit with the TAR.

What is the start date of their 6 month authorization period?
January 1, 2022.

Are there any steps required before we can submit claims?
ECM providers may begin to bill PHC for all ECM outreach and service codes.
For provider payment, an approved TAR must be on file before you can be paid the successful engagement fee and PEPM. Once the TAR has been approved, you will receive an ECM TAR approval letter.

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What is the file-naming convention for the Care Plan and Release of Information pdf files that we are uploading to Collective Medical?

ROI:

Format-ROI County/Provider Exp.mm/yy Member CIN #
Example-ROI Marin Exp. 05.18.26 CIN 123456789.pdf

Care Plan:

Format-CP County/Provider Date Member CIN #
Example-CP Marin 05.18.26 CIN 123456789.pdf

Can we get verbal consent instead of wet signature for the ROI?

As of right now, a wet signature is required. We are pending additional DHCS guidance to confirm if a verbal consent will suffice instead of a wet signature for the ROI.

Do we need to bill using units?

Yes, you will need to bill using units per DHCS mandate. 1 unit is 15 minutes.

Do we need to report all outreach attempts on the claim and the report?

As a DHCS requirement all outreach needs to be submitted via billing (claim or invoice) and on the Initial Outreach Tracker (IOT) reporting file.

Clinical vs non-clinical engagement and outreach -- are both forms of outreach required monthly?

No both are not required. It depends on the care plan and the members' needs.

Will the monthly billing periods start during the last week of every month?

Billing can be done as often as you would like. You can do it based on how much service you are rendering.

We already submit electronic claims to Partnership - are there any changes we need to make in relation to electronic payer ID or can these claims simply be included with all other claims?

If you currently bill PHC electronically, you do not need to do a new setup; however, you need to have a HIPPA Compliant 837 file signed/completed. As a reminder:

- Providers have one year (365 days) to submit claims from the date of service (DOS). The faster you submit claims, the faster the reimbursement
- Clams will be processed within 30 calendar days

Will we know if there are other patients who should be assigned to us within our service area?

You will receive a Targeted Engagement List (TEL) file monthly with your assigned members. Please report any additional identified members in your ECM Provider Return Transmission File (RTF).

How do we get more members assigned to us?

It is important that you indicate your organization's capacity in the monthly ECM provider capacity survey. This information will indicate you are capable of taking on additional members.

CalAIM: Enhanced Care Management (ECM) Frequently Asked Questions

How do we document unanswered outreach attempts for enrolled patients, if at all?
This will be documented in the ECM Provider Return Transmission File (RTF) in the applicable encounter counts fields. The ECM provider should also bill the applicable outreach attempt HCPCS.

Is there a way to get a list of Community Support providers so we can refer patients to them?
We are working on updating our provider directory to include a Community Support indicator.

Did DHS provide guidance on what should be included in a care plan?
DHCS has indicated the care plan is based on the member's goals, health status, needs, and preferences regarding physical health, mental health, disabilities, substance use, oral health, community-based long-term services, and supports, supports to manage serious illness, trauma-informed care needs, and community and social services.

Outreach reporting - Please clarify telephonic outreach. I believe we are supposed to count all attempts even failed calls? Failed calls will definitely be less than 15 min. May we count these attempts as 1 unit?
Yes, you will count all attempts made which includes failed calls or unsuccessful outreach. The ECM provider may bill 1 unit even if it is less than 15 minutes.

How do we make sure the CHW's are working and charting into this within their scope. How do we do that?
The state is still discussing that role even for credentialing.

Am I hearing correctly that referrals will be sent to the assigned provider once a month? Or will we be receiving referrals via the Collective Medical platform on an ongoing basis?
Yes, ECM providers will receive their Targeted Engagement List (TEL) file with their assigned members monthly through the Collective Medical platform.

Did we get a response from DHCS to list who qualifies as licensed staff?
DHCS has not yet provided a definition or list of who is considered clinical or licensed staff.

How do we document unanswered outreach attempts for enrolled patients?
This will be documented in the ECM Provider Return Transmission File (RTF) under the applicable encounter counts and the ECM provider will bill PHC for the applicable outreach attempt HCPCS.

It was a little unclear if we need to document/report the actual number of contacts with each patient per month. Please clarify.
This will be documented in both the monthly reporting and billing. For reporting, this will be captured in the ECM Provider Return Transmission File (RTF) and you will include this in the applicable encounter count fields (in-person vs. telephonic). The ECM provider will also need to bill PHC for any ECM services with the applicable HCPCS.

If we identify patients that we think qualify, is that an ongoing submission through the TAR process?
Please include these members' in your ECM Provider Return Transmission File (RTF).

CalAIM: Enhanced Care Management (ECM) Frequently Asked Questions

January 26, 2022

When will the ECM benefit go-live?
Partnership HealthPlan of California (PHC) will launch the first three (3) of the seven (7) Populations of Focus on January 1, 2022 in the following five counties Marin, Sonoma, Napa, Mendocino and Shasta

Which Populations of Focus will launch on January 1, 2022?
Homeless – Adults and Children/Youth, High Utilizers – Adults, Serious Mental Illness (SMI) and Substance Use Disorder (SUD) – Adults.

Are ECM Providers required to serve all eligible ECM target populations?
No. ECM Providers may serve one or more of the ECM target populations or a subset of target populations with which they have experience and expertise.

Do ECM Providers need to be Medi-Cal enrolled?
Yes. ECM Providers must be Medi-Cal enrolled. For more information on Medi-Cal enrollment, visit the Department of Health Care Services (DHCS) Provider Enrollment Division (PED) at https://www.dhcs.ca.gov/provgovpart/Pages/PED.aspx

Who needs to be credentialed for ECM?
PHC only credentials providers that have a pathway to Medi-Cal MD, DOs, LCSWs, LMFTs, NPs, PAs, etc. PHC does not credential RNs. The list of provider types supported by DHCS' Provider Application and Validation Enrollment (PAVE) can be found on the DHCS website at Provider Types Supported in PAVE.

Are Behavioral Health and Recovery Services (BHRS) ECM providers required to enroll in PAVE?
Per DHCS, county clinics need to enroll in PAVE or with DHCS as a Medi-Cal site.

Are patients with dual health coverage like Medicare and Medi-Cal eligible to receive ECM? If yes, why are they being excluded from the patient file being sent to Collective Medical?
Yes, Medi-Medi's are eligible for ECM. The patients you see now in the Collective Medical Portal are not specific to ECM. Once the benefit goes live the Medi-Medi's eligible for ECM will be included and visible.

There is a concern over the Collective Medical timeline of 60-90 days for those WPC providers that were considered under the county delegate and are now working directly with PHC.
PHC urges providers to contract Collective Medical and open that communication channel as soon as possible. Please contact Collective Medical at: support@collectivemedical.com and (801) 285-0770

Do you have a specific social determinants of health screening that you will want providers to use?
No. There is no specific screening tool at this time. We will update providers with additional resources as we confirm them.

Concerning population of focus, Homelessness, who will determine that coordination of services would likely result in improved health outcomes and/or decreased utilization of high-cost services?
Individuals experiencing or at risk of homelessness are among the highest-need individuals in Medi-Cal. They often lack access to necessities such as food and shelter that are critical to attaining health. The assigned ECM Lead Case Manager will meet with the member and work together to determine the best course of action for the member in improving health outcomes and decreasing high utilization of services.

Population of focus three states that an individual may qualify for ECM services if they (1) meet the eligibility criteria for a.) the specialty mental health system or b.) the drug Medi-Cal organization delivery system or c.) Drug Medi-Cal Program. I am not familiar with what makes an individual eligible for these three programs, can you please elaborate?
Please refer to the DHCS information on Medi-Cal Specialty Mental Health Services. Below is the website link.
https://www.dhcs.ca.gov/services/Pages/Medi-cal_SMHS.aspx

Do you have the form required for Care Plans?
There is no required form for care plans. You may use your current form, or use the template available on our website
http://www.partnershiphp.org/Community/Documents/CalAIM%20Webpage/ECM%20Documents/ECM%20Care%20Plan%20Final.pdf

Are there specific assessments that need to be submitted in addition to the care plan (staying healthy assessment, PHQ2/9, audit c, trauma screening etc.) and will periodically updated care plans and assessments be part of deliverables?
Care plans are required. Periodical updates on care plans are required for Treatment Authorization Request (TAR) renewals. Other assessments are not required at this time for the ECM benefit.

Will the LVN or RN still need to complete a Med Rec the first three (3) months of enrollment and then every other month after (such as IOPCM)?
No. ECM is different model of Case Management than the IOPCM program. For ECM, PHC requires that an Individualized Care Plan (ICP) is to be filled out and a Release of Information (ROI) for ECM to be signed by the member. The ECM provider should assist the member in reviewing medications with the appropriate provider/agency when needed (ex: the member's provider, nurse, pharmacist, etc.). The member's ICP does not need signature, oversight or approval from an RN or any licensed clinician.

When do we need to resubmit a care plan?
The care plan should be updated and submitted to PHC whenever a new TAR or a renewal TAR is submitted to PHC. The care plan is a working document between the ECM provider and the member and documents progress towards a member's goals while receiving ECM services.

Where is the centralized place where staff can begin their ECM case management trainings?
At this time, PHC does not provide direct ECM Case Management training. We have resources available on the website for billing and reporting that you can access. Additionally there is a Comprehensive Assessment and Care Management Planning section in the provider tool kit created by DHCS and Aurrera. We strongly encourage our ECM providers to review this tool to understand the ECM model and development of their ECM team & internal processes.
http://www.partnershiphp.org/Community/Documents/CalAIM%20Webpage/ECM%20Documents/Provider-Toolkit_FINAL.pdf

Do we need to submit new care plans for patients transitioning from WPC/IOPCM by end of Jan and how do we do that?
No. For members transitioning from WPC/IOPCM, PHC requests that you meet again with these members and obtain an updated ROI and begin/revise their ICP. The transitioning member's ROI and ICP is due with the renewal TAR no later than 6/30/2022.

Do CHWs start the care plan and how do CHW's document that it is legal and within their scope of practice?
Per DHCS guidance, Community Health Workers (CHWs) are authorized to act as an ECM Lead Care Manager for the ECM benefit. This includes developing and maintaining the member's Individualized Care Plan (ICP) for ECM. DHCS is currently working on a pathway for CHWs to becoming Medi-Cal certified provider type and more information from DHCS is forthcoming.

Do we now call the Action Plan the Care Plan?
Action Plan is an IOPCM program term. For ECM the member shall have an Individualized Care Plan (ICP). The ICP may have some of the same information as the Action Plan. For more information see:
http://phcwebsite/Community/Documents/CalAIM%20Webpage/ECM%20Documents/ECM%20Care%20Plan.pdf

What does monthly documentation look like?
There are three (3) Domains of monthly documentation for ECM Providers: DHCS required reporting, Billing, and Service-Level Documentation (ex: care plans, ROIs)

1. DHCS Required Reporting (monthly):
The ECM provider will submit the following three (3) separate reports to PHC through the secure File Transfer Protocol (sFTP) data exchange:

a) ECM Provider Return Transmission File (RTF): The ECM provider will need to complete the template for any pre-populated members and any newly ECM-eligible members identified by the ECM provider.
b) Initial Outreach Tracker File (IOT): The ECM will complete the template to track any outreach attempts for that month. Outreach efforts should only be tracked for all members who have been identified as eligible for ECM. Once a member is enrolled in ECM, they should not be tracked on the IOT report.

ECM Provider Capacity Survey: The ECM provider will be emailed a hyperlink to a Google Forms survey. The ECM provider shall fill out this report monthly so that PHC can analyze capacities for referral management, and report capacity volumes to DHCS as required.

2. Billing:

PHC highly encourages that all ECM providers remit their invoice(s) and/or claims within 30 days from the service date.

3. Service – Level Documentation:

ECM providers are responsible for keeping the members' ICP and ROI's current and up-to-date.

Will patients who have a Release on Information (ROI) from Whole Person Care still be required to submit a brand new ROI?

Yes, we will need an ROI specific to ECM. We have one you are welcome to use on our website if you do not currently have one in place. See below next question and link.

Providers can use the PHC ROI form on our website at http://www.partnershiphp.org/Community/Pages/CalAIM.aspx

ECM ROI:
http://www.partnershiphp.org/Community/Documents/CalAIM%20Webpage/ECM%20Documents/ECM%20ROI%20Form_Eng_Draft_Updated%2012.21%20final.pdf

Can the ROI consent be a verbal consent due to COVID (as IOPCM and WPC allowed)?

At this time, ECM providers must obtain written consent from the member. PHC will continue to review with our association and DHCS.

Will we need two different Collective Medical logins if we have ECM patients from two (2) different health plans?

No, you will not need two different account logins. Collective Medical is able to populate one portal with multiple TEL files.

Will we get an upload once a month with the Targeted Engagement List (TEL)?

Yes. PHC will upload the Targeted Engagement List (TEL) to Collective Medical once a month for the ECM Provider to review and begin outreach. The TEL list includes new referrals from PHC to the ECM provider.

Is PHC ready to accept referrals for new enrollees in ECM?

Yes, PHC is ready to accept referrals for new enrollees in ECM. There is no wrong door for ECM referrals and they can be routed to PHC in a variety of avenues. We have developed an external ECM referral form at the below link. Note this is not required but was created as a guide.
http://www.partnershiphp.org/Community/Documents/CalAIM%20Webpage/ECM%20Documents/ECM%20Referral%20Form.pdf

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An ECM referral may also be done by calling PHC's Care Coordination (CC) Department at 800-809-1350. ECM provider may indicate a newly identified member on the ECM Provider Return File (RTF) to PHC.

Does the reporting apply to those who are doing electronic billing?
Reporting applies to all ECM providers regardless of how you bill. Reporting and billing are two separate DHCS requirements.

Since we do not credential RN's is this program more of 'certification' vs credentialing?
PHC credentials the organization, so you will need Certificate of Insurance, W-9, and enrollment in MCAL if there is a pathway, startup document, etc. If you have contracted with us, you have received the information.

Will referrals to ECM staff from a dentist, medical and/or behavioral health provider count as clinical staff outreach?
No. Members referred to your ECM team for services by either an internal or external clinician, should not be tracked or counted as clinical staff outreach.

Can PHC list the type of staff qualified as clinical providers for code G9008
DHCS has not released details on who qualifies as 'clinical providers'.

Will all service codes require a TAR?
Yes. All service codes require a TAR.

Is there a limit on TAR renewals for ECM?
ECM TARs are approved on a 6-month basis.

What attachments need to be submitted with the TAR?
You will need to submit both the ROI and the care plan with your TAR **and** on the Collective Medical platform.

Do we need to submit an ROI and a care plan for existing WPC and IOPCM members who are going to transition come 1/1/22?
The ROI will be required. The care plan will be required for transitioning members at the TAR renewal date.

Is the one-time successful engagement fee a once in a lifetime fee or can it be accessed if someone leaves ECM services and later returns?
Yes, once every 12 months, which is defined as a rolling 12 months, not a calendar 12 months. The member must have a gap in ECM services for 12 months before the engagement fee can be billed again. A TAR will be required.

Is a TAR required in order to be paid for the $150 outreach reimbursement?
Yes, a TAR is required.

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Where can PHC's ECM policy MCCP2032 be found?
Policies will be available on PHC's website upon approval by DHCS. You may also refer to DHCS' CalAIM Enhanced Care Management Policy Guide document.

Which modifiers are required for the TAR?
Please refer to DHCS' ECM and Community Supports (ILOS) Coding Options for more information on codes including applicable modifiers

What is the definition of code G9012 Successful Engagement?
Successful engagement is defined as a member agreeing to enroll in ECM, signing the Release of Information (RO)I for ECM services, and starting the care plan to address the member's needs.

If we are not able to reach out to the patient after 3 attempts (within 1 month), do we have to resubmit a TAR to keep enrollment or can we continue enrollment for next month and making efforts to re-engage the patient?
Once the member agrees to be enrolled in ECM, the ECM provider shall submit a TAR to PHC. PHC's TARs for ECM can be approved for up to six (6) months. It is the expectation that the ECM provider meet with the patient at least once per month. If after multiple attempts the ECM provider is unable to reach the member, and the member ceases to be found or engaged with their ECM lead care manager, the ECM provider shall discharge the member from the program after all reasonable attempts to locate and engage the member.

Are there minimum time requirements for the case management ECM Case Management codes? Providers should bill for ECM outreach and/or services in 15-minute increments. One unit equals 15 minutes.

Do we use a claim form or the excel worksheet?
You may continue to use electronic billing if you have tested with our EDI team. If you do not currently bill PHC electronically, you may utilize the invoice excel worksheet, or submit on the CMS-1500 claim form.

Does PHC accept electronic billing?
Yes. Electronic claims submission is encouraged and allows for faster reimbursement. If you do not bill electronically, you can start the process with our Electronic Data Interchange (EDI) Team at 707-863-4527 or email EDI-Enrollment-Testing@partnershiphp.org.

What are the billing codes that would be required for ECM?
DHCS released and updated billing codes and guidelines which can be found in the finalized ECM and Community Supports (ILOS) Coding Options document.

Should RNs and LCSWs use G9008?
Please refer to DHCS' ECM and Community Supports (ILOS) Coding Options for more information on codes including applicable modifiers.

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Are licensed ECM behavioral health providers able to bill behavioral health visits to the same patient on the same service date?
Yes. A licensed BH provider may provide both ECM and billable behavioral health visits on the same service date. These services must be billed separately to PHC and not appear on the same claim or invoice.

If we are already billing PHC electronically will we need to retest?
No. Providers who currently bill electronically do not need to retest.

How do I use the excel invoice sheet?
Our Claims Resolution Coordinators can provide training on how to complete the invoice excel spreadsheet. Please email the following contacts for claims questions:
ECM Providers please contact: Claimsecmhelpdesksr@partnershiphp.org
Community Supports Providers please contact: Claimsecmhelpdesksr@partnershiphp.org

Do we have to separately bill for the outreach done to members?
Yes, each outreach attempt needs to be billed separately. This is important and required reporting data to DHCS for the ECM benefit.

Is there training for how to conduct the billing?
Please reach out to our Claims Team: Claimsecmhelpdesksr@partnershiphp.org

How can I access the Provider Online Portal?
Click here to access the portal https://provider.partnershiphp.org/UI/Login.aspx. If you need further sign-up assistance or training on the Provider Online Portal, send an email to esystemssupport@partnershiphp.org to schedule one on one training.

When will PHC hold the bimonthly provider roundtables?
The 2022 ECM Provider Roundtables are scheduled from 12-1:00 PM on the following dates. You may register at the link for the ECM Provider Roundtables

- January 13, 27
- February 10, 24
- March 10, 24
- April 7, 21
- May 12, 26
- June 9, 23

Is there a link to the provider eTAR training available?
Email esystemssupport@partnershiphp.org to schedule eTAR and Provider Portal training

Can I submit a question before the roundtable?
Yes. You can submit roundtable questions to esystemssupport@partnershiphp.org by the Monday before each scheduled roundtable

To whom do we submit contract questions and signed contracts?
Contracts and contracting questions can be submitted to contracting@partnershiphp.org