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INTRODUCTION

Please review the following guide before creating an account for a group or clinic in the State Level Registry (SLR). Please be aware of the following:

- Some groups/clinics may be unable to register in the SLR because of not being found in Department of Health Care Services’s (DHCS) Provider Master File (PMF). Such groups/clinics should contact the SLR Help Desk which will be able to add them to a “supplementary” PMF list that will enable them to register in the SLR. The SLR Help Desk may be contacted by phone, (855) 649-7806, or e-mail, CASLRSupport@us.ibm.com.

- The SLR asks the question whether a clinic is a Federally Qualified Health Center (FQHC), FQHC look-alike, Rural Health Center (RHC), or Indian Tribal Clinic. Only click “Yes” to this question if the clinic is one of these types and will need to count “Other Needy Individual Encounters” (in addition to Medicaid Encounters) in order to attain the >30 percent patient volume threshold. If the clinic will meet this threshold counting only Medicaid encounters do not click “Yes” to this box. Clicking the box limits the number of eligible providers in your clinic to those who practice predominantly in your clinic.

- Effective for 2017, group/clinic representatives may enter any provider into their group who had at least one encounter with a Medi-Cal patient (or other needy individual patient for FQHCs/RHCs) with the group/clinic during the relevant calendar year or the 12 months preceding attestation. For groups/clinics that applied for the 2017 payment year, this meant that any provider that saw a Medi-Cal (or other needy individual) patient in 2016 or the 12 month period prior to attestation with the group/clinic was able to qualify using the group/clinic patient volumes for the 90-day representative period in 2017 even if all of the provider’s encounters in 2016 occurred outside of the 90-day representative period. Group/clinic representatives who have already registered in the SLR should contact the SLR Help Desk to reopen their group/clinic registration by sending an e-mail to CASLRSupport@us.ibm.com. Please specify “Add Providers” in the subject line and provide the same information specified above. While adding providers, the group/clinic representatives should be careful to not change the group/clinic patient volumes for the 90-day representative period. The group/clinic representative should have included all encounters by all providers practicing in the group/clinic for the 90-day representative period during the initial registration and although providers practicing in a group/clinic outside of this 90-day period can qualify with the group/clinic their encounters should not be included in the patient volume calculation.
• The SLR asks whether a group or clinic is composed entirely of pediatricians. Only click “Yes” to this question if all the group providers are pediatricians and the group/clinic will only qualify at the 19.5-29 percent Medicaid level. If the group will qualify at the ≥30 percent Medicaid level do not check “Yes” to this box. Checking “Yes” unnecessarily will result in all of the group providers needing to upload documentation of their board certification or board eligibility.

• Anyone can enter the SLR as a representative of the provider by entering the provider’s National Provider Number (NPI) and Tax Identification Number (TIN)/Social Security Number (SSN). However, when a proxy representative enters information on behalf of a provider, a notification e-mail will be sent to the provider. A proxy representative who is also serving as clinic or group representative should not enter the TIN for the clinic or group. This will cause the provider to be not found in the SLR, thus preventing the proxy representative from being able to enter the provider’s information. Entering the provider’s TIN or SSN will not affect any reassignment of payments to the clinic or group that has been designated when registering with the Centers for Medicare and Medicaid Services (CMS) Registration & Attestation Site.

• Some groups or clinics may receive the message “Provider information not found” when attempting to enter some providers into their group/clinic. This will usually result when the provider is not listed in DHCS’s Provider Master File (PMF) because they have not established themselves as a billing or rendering provider for Medi-Cal Fee-for-Service. Providers associated with the group/clinic that are not in the Provider Master File are encouraged to register with the CMS National Level Registry (NLR) before designation as providers in the group/clinic. After registering the group/clinic in the SLR, the group/clinic account can be reopened by contacting the SLR Help Desk. However, only providers who have subsequently either registered with the NLR (up to a 3 day process) or have become providers in the DHCS Provider Master File (potentially a several week process) can be added. Groups may have professionals who are not eligible to apply but are still contributing to the group’s volumes (for example dieticians may contribute to patient encounters but are ineligible for the program). In this scenario, if the NPI of the professional cannot be added in the SLR, group representatives must upload a letter listing the names and NPIs of those providers who cannot be added to their group. This letter can be uploaded in the “Upload Files” section in Step 4: EHR Technology and Group Statement. Please note that providers who are eligible for the program should be added to the group by entering their NPI in Step 3 of the SLR and clicking “add,” otherwise, the provider will be unable to utilize group volumes when they register.
• If a provider who has been prequalified by DHCS based on their individual Medi-Cal encounters has registered with the SLR before the group/clinic of which they are a potential member has registered, this does not preclude subsequent group registration. Group/clinic representatives entering prequalified providers into their group/clinic should upload a letter with their application listing the prequalified providers’ names and NPIs. The encounters of the prequalified providers should be included in the group/clinic patient volumes for the 90-day representative period. OHIT staff will subsequently contact these providers to confirm that they are willing to change the basis of their eligibility to qualify based on group/clinic patient volumes. If these providers are unwilling to do this the group/clinic administrator will be notified of the need for all providers in the group/clinic to establish eligibility using individual patient volumes. To minimize this possibility, group/clinic representatives should check with any prequalified providers who may have registered with the SLR before establishing the group/clinic in the SLR.

• Proxy representatives entering data on behalf of providers who have been prequalified or identified as qualified with a group or clinic will find that some or all of the eligibility page data entry fields have already been completed and cannot be edited by the proxy representative.

• Proxy representatives cannot choose to opt-out of a group or a clinic for the provider, thus closing the group or clinic to other providers. This action can only be taken personally by the provider.

• As described above, the group/clinic representative’s letter should also contain the names and NPIs of providers who could not be entered into the SLR because they could not be found in the PMF.

• DHCS prequalifies clinics based upon patient encounter data they have submitted to the Office of Statewide Health Planning and Development (OSHPD) for the preceding calendar year. The 2020 prequalification list for clinics will not be available until July 2020. However, DHCS plans to allow clinics to use the 2019 prequalification list to initially register for 2020, but payment will not be issued until eligibility is confirmed by the 2020 prequalification list or the submission of encounter data by the clinics. DHCS hopes to have the 2020 prequalification list for professionals available by April 1, 2020.

• Beginning in 2019, DHCS requires that documentation for meaningful use be uploaded to the SLR before a MU attestation can be reviewed and approved. This documentation should include a copy of the MU dashboard report produced by the electronic health record or an equivalent data source. The documentation should also include a copy of the Security Risk
Analysis (SRA) or a signed letter describing the SRA. A SRA letter template can be found on the SLR website. The documentation can uploaded to the group/clinic SLR account by the group/clinic representative if it breaks out MU data for each provider in the group/clinic. SRA documentation does not have to be specific for each provider. Any upload button in the SLR can be used for this purpose. Additionally, uploading documents to the account after submission can be done by clicking on the “Upload Files” button on the dashboard.
REGISTERING ON THE STATE LEVEL REGISTRY (SLR)

Group representatives must register their group/clinics with the state on the **State Level Registry (SLR)**.

Although providers and hospitals are required to register with CMS on the CMS Registration and Attestation Site (in addition to registering at the SLR), group representatives will only apply in the SLR.

I. **Creating an Account**

In order to create an account, visit the [State Level Registry](#) and click on “Create Account.”

The SLR offers the option to either choose “Group Representative” role or “Proxy Representative” role. For the creation of a group representative account, the group/clinic’s NPI and TIN will be needed.

The creation of a proxy account allows a representative to enter information on behalf of the provider(s). Proxy representatives have access to the same webpages as a provider. The provider must still review and attest to the accuracy of the information entered by the proxy representative.

**Note to Prequalified Clinics Only:** If the clinic has been prequalified, ensure that the NPI and TIN entered is the same NPI and TIN that was provided to DHCS in the clinic prequalification questionnaire.
If “Group Representative” was selected, verify the clinic name and address before completing the registration process. If the information is correct, select “Continue.”
After selecting “continue,” enter the required information to create an account. The same information is entered when registering as either a “Group Representative” or a “Proxy Representative.”

Create Account

Enter your contact information.

Create Login

Create your account username and password.

Proxy Home: Searching for Providers

Those that have registered as a “Proxy Representative” will need to add each provider that they will be acting as proxy representative. To search for the provider, enter the provider’s NPI and TIN/SSN. This should be the same NPI/TIN that the provider used when registering with the CMS Registration and Attestation site.
II. Step 1: About Your Group

Confirm that the provider displayed is correct, then click the “Proxy” button to begin entered data. If the provider is not found, it may be because they have not registered with the CMS Registration and Attestation site.
Step 1 in the SLR requires the Group Administrator to enter their contact information which includes name, telephone number, and email address:

![Image of State Level Registry (SLR) Interface]

**About You (As Proxy)**

After selecting the “Proxy” button next to the chosen provider, the provider’s account will be displayed. The provider’s name will display in the header of the SLR, which allows for confirmation that data is being entered for the correct provider.
Enter the provider’s contact information:

**License Information (Proxy)**

Enter the provider’s license information, special practice types(s), and Medi-Cal Managed Care Health and Dental Plan affiliation(s).

- I have a California professional license.
  - Licensing Board
  - License Type
  - License Number

- I practice primarily in an Indian Tribal Clinic or a Federal Clinic and do not have a California License.
  - Other State
  - Other State License Number

- I do not have a California license and do not practice in an Indian Tribal Clinic or a Federal Facility.

Special Practice Types

- Hospital Based
  - Did you perform 90% or more of your professional services in an inpatient hospital setting or an emergency room attached to a hospital in the previous calendar year?
    - No
    - Yes

- Physician Assistant
  - I am a physician assistant (PA) and practice in a Federally Qualified Health Center (FQHC), Federally funded rural health center, or Indian Tribal Clinic that is PHS.
Group/Clinic Participation (Proxy)
The final part of Step 1 is selecting how the provider will participate in the program – with a group (if applicable) or on their own as an individual provider.

If the provider is part of a group/clinic, the option to choose to participate with the provider’s group/clinic and establish eligibility for the program using information entered by the group/clinic is available. Once the group/clinic representative creates an account and adds the provider as a member of their group/clinic, the group will be available for selection as shown below. If the provider is a part of multiple groups, all groups that he/she has been added to will be listed.

Alternatively, the provider has the option not to participate with their group/clinic and instead establish eligibility on their own.
III. Step 2: Group/Clinic Information

In order to determine group/clinic eligibility, group representatives will be required to enter aggregate volumes for all providers in their group/clinic. In addition, the locations for these volumes will also be required.

Group/clinics must meet 29.5 percent Medicaid volumes (groups of only pediatricians can qualify with 19.5 percent Medicaid volumes). FQHC, RHC, FQHC Look-Alikes, or Indian Tribal Clinics can qualify with 29.5 percent Medicaid + Other Needy Individual volumes.
Location Information
Group representatives and proxy representatives must enter the NPI and address for each location where volumes are being derived, there is no limit to the number of locations that can be added.

This section addresses the requirement to Adopt, Implement, or Upgrade (AIU) to a certified EHR Technology. By clicking the "Use this location to fulfill AIU (in part or in full)" box, the group representative can indicate that the certified EHR technology has been or will be adopted, implemented, or upgraded at this address.
Specialty Group Type and Practice
Selecting a specialty group type and/or practice will determine which formulas may be used to calculate the group/clinic’s eligibility. If the clinic has been prequalified, the options below will not display.

- **FQHC, RHC, FQHC Look-Alike, or Indian Tribal Clinic**
  Checking the FQHC, RHC, FQHC Look-Alike, or Indian Tribal Clinic box will enable the group to include Other Needy Individual encounters to the Medicaid encounters.

  **Please note:** This box should only be checked if Other Needy Individual encounters will be used. A FQHC, RHC, FQHC Look-Alike, or Indian Tribal Clinic that does not need to include Other Needy Individual encounters to qualify should not check this box.

- **Pediatric Practice**
  Checking the Pediatric Practice box will enable pediatric groups to qualify with 19.5 percent - 29 percent Medicaid volumes for an incentive payment that will be reduced by one third. Pediatric groups cannot qualify at the 19.5 percent - 29 percent needy level. All providers in the group/clinic will be required to provide proof that they are pediatricians when registering by uploading documentation of board certification or board eligibility with the American Academy of Pediatrics or the American Osteopathic Board of Pediatrics.

  **Do not** check this box if the group will be able to qualify at the 30 percent Medicaid level.

90-Day Representative Period
Groups must first choose the 90-day representative period from which patient volumes will be derived. If the clinic is prequalified, this section will not display. There are two approaches available
90-Day Representative Period in the *Previous Calendar Year*:
The representative period must start and end in the calendar year preceding the program year for which you are attesting. Note that the 90-day representative period selected must not overlap with the 90-day representative period used for your previous program year attestation.

90-Day Representative Period in the *12 months prior to attestation*:
The representative period must start and end in the 12-month period preceding the date that the provider submits their attestation. Note that the 90-day representative period selected must not overlap with the 90-day representative period used in the previous program year attestation.

**Formula Selection**
Choose the formula that you would like to use to calculate your group/clinic’s eligibility. If the clinic has been prequalified, the options below will not display.

**Formula Selection**
These formulas affect how your incentive payment is calculated. Your available formula options are determined by whether your group/clinic predominately practices in an FQHC or RHC.

- **FQHC/RHC Formula 1B**
- **FQHC/RHC Formula 2B**

Formulas:

- FQHC/RHC 1B: \[
\frac{\text{Total Medicaid Encounters} + \text{Total Other Nearly Indivisuals Encounters}}{\text{Total Patients Encounters}}
\]

- FQHC/RHC 2B: \[
\frac{\text{Total Medicaid Patients Assigned to a Panel} + \text{Total Patients Assigned to an Other Nearly Indivisuals Patient Panel}}{\text{Total Medicaid Encounters} + \text{Total Other Nearly Indivisuals Encounters}}
\]
Patient Volumes
If the clinic has been prequalified, the options below will not display. Groups that are not prequalified will need to enter the aggregate patient volumes for all providers in the group:

<table>
<thead>
<tr>
<th>State</th>
<th>Total Patient Encounters</th>
<th>Total Medicaid Encounters</th>
<th>Total Other Needy Individual Encounters</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>CA</td>
<td>100</td>
<td>10</td>
<td>20</td>
<td></td>
</tr>
</tbody>
</table>

Click the save icon after entering the group volumes in order to calculate the patient volume:

Medicaid Volume Percentage
Formula Used: 1B

0.00 %

Supporting Documentation for Medi-Cal Encounters
Groups/clinics are required to upload auditable documentation, such as a report from their practice management system, showing the group/clinic encounters during the selected 90-day period. In addition, a cover letter that clearly explains how to interpret the documentation and how the Medi-Cal Encounters were derived should be included. For details on what documentation is acceptable, review the...
**Medi-Cal back-up documentation requirements.** If the clinic has been prequalified, the options below will not display.

Under Step 3, group representatives are required to add to the group all providers who:

1. contributed to group encounters during the representative period, and
2. are one of the eligible provider types (physician, nurse practitioner, certified nurse midwife, dentist, physician assistant, optometrist).

There has been a misconception that if an eligible provider is not planning to apply to the program, or is not currently with the group that they should not be added to the group.
the group. This is not the case. All eligible providers that contributed to group volumes during the 90-day representative period chosen in Step 2: Group/Clinic Information must be listed as group members (note: if the group is prequalified, then all providers who contributed to group encounters during the 1-year representative period used to determine prequalification must be listed).

Proxy representatives cannot choose to opt-out of a group or clinic for the provider, thus closing the group or clinic to other providers. This action can only be taken personally by the provider.

Groups should not add providers as members of their groups who contributed to group encounters but who are not one of the eligible provider types (e.g. pharmacists, dieticians). However, groups can upload a letter into the SLR listing the names and NPIs of these non-eligible providers. This may be useful if the group is requested to provide supporting documentation for its patient volumes in a subsequent audit.

Additionally, providers who did not contribute to group encounters during the representative period, but had at least one Medicaid encounter with the group within the same calendar year as the representative period or within the 12 months prior to the EPs attestation, can also be added to the group and benefit from using the group volumes for eligibility. Beginning in 2017, DHCS requires that documentation of at least one Medi-Cal encounter with the group during the prior calendar year or prior 12 months be uploaded to the group or provider SLR account for all providers. This requirement also applies to all providers in prequalified groups/clinics. Documentation supporting MU attestations that is uploaded to the SLR can be used for this purpose, as long as individual provider names or NPIs are specified.

If a group account was completed in the previous program year, the SLR will import all of the EPs that were added to the group in the previous year. The EPs who appear in the “Providers in Your Group/Clinic” section are already added:
If there are no changes to group's provider roster from the previous year, then select “Save” or “Save and Continue” at the bottom of the page to continue. If providers should be removed from the list, check the “Remove” box (far right column in the snippet above) for each provider to remove. Clicking the “Save” or “Save and Continue” button at the bottom of the page will save the changes.

To add new EPs, type or paste in the NPIs for all of the new providers to be added (each NPI must be on a separate line). Click “Search” to validate that the state has each provider’s information available.
Search results will appear below for each NPI entered. If the NPI is found, it will appear in green with the “Add” box already checked. To confirm, click the “Save” or “Save and Continue” button at the bottom of the pages.

Some of the NPIs entered may not be found and will show “Provider information not found” under the search results. If this occurs, instruct these provider(s) to register on the CMS Registration and Attestation Site before adding them to the group. Please note, that it may take up to three days for registration information from the CMS Registration and Attestation Site to be received into the SLR after which the provider can be added to the group.

**NOTE:** Group members in the SLR can be edited until selecting to “submit” the group application. After clicking “submit,” the account will be view-only. Contact the SLR Help Desk at (855) 649-7806 in order to add more providers to the group.
V. Step 4: EHR Technology and Group Statement

Certified EHR Technology

Group representatives may enter the group/clinic’s CMS EHR Certification ID which can be found on the ONC website.

4. CMS EHR Certification ID

Certified EHR Technology

Group representatives may provide information demonstrating that their EHR technology is certified through the Office of the National Coordinator (ONC). ONC provides a public web service that contains a list of all certified EHR technology, including the name of the product vendor and the product’s unique certification ID, and the meaningful use criteria for which the product was certified. The state is required to validate the verification of the CMS EHR ID information before making any payments.

Your Understanding

Your EHR Certification Information

Enter the CMS EHR Certification ID.

Upload the CMS EHR Certification ID page.
Additionally, the CMS EHR Certification ID page may be scanned and uploaded to the SLR. An example of this page is as follows:

**Certified Health IT Product List**

The CMS EHR Certification ID shown corresponds to the collection of products listed below. Submit this ID as part of the attestation process for the CMS EHR Incentive Programs.

* Additional certification criteria may need to be added in order to meet submission requirements for Medicaid and Medicare programs.

**CMS EHR ID: 0015E244MTA7J5R**

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<td>EpicCare Ambulatory EHR Suite</td>
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</tr>
<tr>
<td>Certification Edition</td>
<td>2015</td>
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<tr>
<td>Relied Upon Software Required</td>
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If the certified EHR certification ID is entered by the proxy representative, the proxy representative will be taken back to the Proxy Home Page after saving. From the Proxy Home page, the proxy representative can begin or complete data entry for other providers (one at a time).

Please note, beginning in 2019, the ONC website is no longer accessible with Internet Explorer. Recommended web browsers include Google Chrome, Apple Safari, Microsoft Edge, and Mozilla Firefox.

**Group Statement & Application Submission**
The group representative is required to print, sign, and upload the Group Representative Statement. This statement summarizes the information entered into the SLR and requires the group representative to confirm that the information is true and accurate.
After completing Step 4, the group representative can click “Save,” or “Save and Continue” in order to be prompted to submit the application to the state.
NEXT STEPS

Once the group representative has submitted the group/clinic application, eligible providers (or the group representative if using express attestation) must individually review and attest to the validity of their application in the State Level Registry before payments can be made to them.

Eligible providers are required to register and create their own accounts on the CMS Registration and Attestation Site and on the State Level Registry before they can review and submit their attestation to the state.

- For more information on groups and clinics, please read “Understanding Groups and Clinics.”
- For more information on what constitutes a Medicaid or Needy Individual encounter for eligibility purposes, please read “Understanding Medi-Cal and Needy Individual Encounters.”