State Level Registry (SLR) Quick Start Guide

For Group/Clinic Representatives
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INTRODUCTION

Please review the following guide before creating an account for your group or clinic in the SLR. We particularly want to call your attention to the following important issues:

• Some groups/clinics may be unable to register in the SLR because of not being found in DHCS’s 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 asks the question whether a clinic is an FQHC, FQHC look-alike, Rural Health Center, 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% 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.

• Group/clinic representatives may now 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 applying for the 2017 payment year, this means that any provider having seen a Medi-Cal (or other needy individual) patient in 2016 or the 12 month period prior to attestation with the group/clinic is 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 CASLRHelpdesk@conduent.com. Please specify “Add Providers” in the subject line and provide the same information specified above. While adding providers 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 the question 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 20-29%
 Medicaid level. If the group will qualify at the ≥30% 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.

- 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. If you know of providers in your group/clinic that are not in the Provider Master File, please encourage them to register with the CMS National Level Registry (https://ehrincentives.cms.gov/hitech/login.action) before attempting to designate them as providers in your group/clinic. After you have registered your group/clinic in the SLR you can reopen your group/clinic to name additional members by contacting the Help Desk, however you will only be able to name 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). Groups likely will 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 via the regular method (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.

- 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. DHCS will not begin prequalifying clinics until May or June of the following year. For example, for Program Year 2017, prequalified clinics will be announced in mid-2018.
REGISTERING ON THE STATE LEVEL REGISTRY (SLR)

Group representatives must register their group/clinics with the state on the State Level Registry:  https://www.medi-cal.ehr.ca.gov/

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

I. Creating an Account

To create an account on the State Level Registry visit https://www.medi-cal.ehr.ca.gov/ and click on “Create Account.”

Choose the “Group Representative” role and enter your group/clinic’s NPI and TIN.

**Note to Prequalified Clinics Only:** If your clinic has been prequalified, ensure that the NPI and TIN you enter is the same NPI and TIN that you provided to DHCS in the clinic prequalification questionnaire.
Upon clicking “Continue,” you will be prompted to verify your clinic name and address before you can complete your registration:
II. **Step 1: About Your Group**

Step 1 in the SLR requires the Group Administrator to enter their contact information which includes name, telephone number, and email address:
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 30% Medicaid volumes (groups of pediatricians can qualify with 20%-29% Medicaid volumes). FQHC, RHC, FQHC Look-Alikes, or Indian Tribal Clinics can qualify with Medicaid + Other Needy Individual volumes.

**Location Information**
Group 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 A.I.U. (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.
2. Group/Clinic Information

Specialty Group Type and Practice
(This section will not display for prequalified clinics)

Selecting a specialty group type and/or practice will determine what formulas are available for you to choose to calculate your group/clinic’s eligibility.

- **FQHC, RHC, FQHC Look-Alike, or Indian Tribal Clinic**
  Checking the FQHC, RHC, FQHC Look-Alike, or Indian Tribal Clinic box will enable your group to include Other Needy Individual encounters to your Medicaid encounters.
  
  **Please note:** This box should only be checked if Other Needy Individual encounters will be used. If you are an FQHC, RHC, FQHC Look-Alike, or Indian Tribal Clinic and do not need to include Other Needy Individual encounters to qualify, **do not** check this box.

- **Pediatric Practice**
  Checking the Pediatric Practice box will enable pediatric groups to qualify with 20%-29% Medicaid volumes for an incentive payment that will be reduced by 1/3. Pediatric groups cannot qualify at the 20%-29% 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% Medicaid level.

### Specialty Group Type and Practice

The following selections determine the formulas available to calculate your eligibility:

**FOHC, RHC, FQHC Look-Alike, or Indian Tribal Clinic**

[ ]

This box should only be checked if your clinic is an FQHC, RHC, FQHC Look-Alike, or Indian Tribal Clinic and will be including Other Needy Individual encounters in order to qualify.

**Pediatric Practice**

[ ]

90-Day Representative Period

(This section will not display for prequalified clinics)

Groups must first choose the 90-day representative period from which patient volumes will be derived. 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
(This section will not display for prequalified clinics)
Choose the formula that you would like to use to calculate your group/clinic’s eligibility.

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

Patient Volumes
(This section will not display for prequalified clinics)
Enter the aggregate patient volumes for all providers in your group:
You will need to click on the save icon after entering your volumes in order to calculate your volume:

**Supporting Documentation for Medi-Cal Encounters**

*(This section will not display for prequalified clinics)*

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: [http://www.dhcs.ca.gov/provgovpart/Documents/OHIT/Backup_Documentation.pdf](http://www.dhcs.ca.gov/provgovpart/Documents/OHIT/Backup_Documentation.pdf)
You are required to upload additional documentation to support your patient volumes. Please click here for guidance on acceptable documentation.

**Other Documentation**

[Upload File]

File(s) Attached - [1]

✅ Meets Medicaid Eligibility Requirements? Yes
IV. Step 3: Manage Providers in Your Group

Under Step 3, group representatives are required to add to their 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. 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).

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 you have completed a group account in the previous program year, the SLR will import all of the EPs that were added to your 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 your provider roster from the previous year, then you can simply “Save” or “Save and Continue” at the bottom of the page to continue. If you need to delete providers from the list, you can check the “Remove” box (far right column in the snippet above) for each provider you would like to remove.
You will need to click the “Save” or “Save and Continue” button at the bottom of the page to save the changes.

To add new EPs, type or paste in the NPIs for all of the new providers you would like to add (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 they are found, they will appear in green with the “Add” box already checked. To confirm, you will need to click the “Save” or “Save and Continue” button at the bottom of the pages.

You may discover that some of the NPIs you enter will not be found and will show “Provider information not found” under the search results. If this occurs, you will need to instruct these provider(s) to register on the CMS Registration and Attestation Site (https://ehrincentives.cms.gov/hitech/login.action) before you will be able to add them to your 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 you will be able to add the provider(s) to your group.

NOTE: You will be able to edit your group members in the SLR until you “submit” your group application. After you “submit,” your account will be view-only and you will be required to contact the SLR Help Desk at (866) 879-0109 in order to add more providers to your group.
Step 4: EHR Technology and Group Statement

Certified EHR Technology
Group representatives may enter in the group/clinic's CMS EHR Certification ID which can be found on the ONC website (https://chpl.healthit.gov).

4. CMS EHR Certification ID

Certified EHR Technology
Group representatives and providers are aware that the EHR technology is certified through the Office of the National Coordinator (ONC). ONC provides a public web service that contains a list of 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 certification of the Certified EHR Technology before sending any payments.

It is the group representative's responsibility to ensure that its certified EHR Technology code is listed on the ONC public web service before submitting the state's quarterly or semiannual incentive application.

Your Understanding

I understand that it is my responsibility, as the group representative, to ensure that the group's certified EHR technology ID is listed on the ONC public web service before submitting the Group Representative Statement to the state.

Your EHR Certification Information

[Provided example of certified EHR technology ID]

Supporting Documentation:

- [Unsupported file]
- [File(s) Attached: (s)]

You are required to submit a copy of the CMS EHR Certification ID page from the ONC website.
Additionally, the CMS EHR Certification ID page may be scanned and uploaded to the SLR. An example of this page is as follows:

![CMS EHR Certification ID](image)

### CMS EHR Certification ID

**Your CMS EHR Certification ID:** 30000001TMKQEAS

An eligible professional or eligible hospital that chooses to participate in this EHR Incentive Program must obtain a CMS EHR Certification ID. You may submit this CMS EHR Certification ID at the time of registration, but may submit this Certification ID as part of the attestation process for either the Medicare or Medicaid incentive program.

Please refer to the Medicare and Medicaid EHR Incentive Programs site and enter this Certification ID when prompted to enter a "HR Certification Number" on the appropriate registration or attestation screen.

### Your Certified EHR Product(s)

The following products were used to obtain your CMS EHR Certification ID:

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<th>Certified</th>
<th>Vendor</th>
<th>Product</th>
<th>Product Version</th>
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<td>Meditech Corporation</td>
<td>DIED 4.7</td>
<td>2.12</td>
<td>HL7 v2.3.1 - all applicable requirements</td>
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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” which can be accessed at: http://www.dhcs.ca.gov/provgovpart/Documents/OHIT/Understanding_Groups_and_Clinics.pdf

- For more information on what constitutes a Medicaid or Needy Individual encounter for eligibility purposes, please read "Understanding Medi-Cal and Needy Individual Encounters" which can be accessed at: http://www.dhcs.ca.gov/provgovpart/Documents/OHIT/Understanding_Medi-Cal_Encounters.pdf