State Level Registry (SLR) Quick Start Guide for Providers

Program Years 2019 - 20

CONTENTS

Version Number	Date	Notes
1.0	12/29/2011	-
2.0	10/10/2012	-
3.0	8/30/2016	Program Year 2015 Updates
4.0	12/13/2016	Program year 2016 Updates
5.0	4/25/2017	Program Year 2017 Updates
6.0	10/23/2017	Program Year 2017 Updates (from 2018 Inpatient Prospective Payment System Final Rule effective 10/1/17)
7.0	10/25/2018	Program Year 2018 Updates
8.0	12/10/2019	Program Year 2019 and Program Year 2020 Updates.

Introduction

The State Level Registry (SLR) is available for eligible providers to apply to the Medi-Cal Promoting Interoperability (PI) Program (formerly the Medi-Cal Electronic Health Record Incentive Program). Eligible providers (EPs) can apply for Program Year 2019 beginning January 2, 2020. Providers will only be able to attest to Stage 3. All providers will have a minimum 90-day MU reporting period. All providers that have reported MU previously will have a one-year clinical quality measure (CQM) reporting period, while those providers that have not reported MU previously will have a minimum 90-day CQM reporting period. EPs are required to report on at least six CQMs related to their scope of practice. EPs are required to report on at least one outcome measure. If no outcome measures are relevant to the EP, they must report on at least one high-priority measure. If there are no outcome or high-priority measures relevant to an EP's scope of practice, they must report on any six relevant measures.

It is important to note that ***Program Year 2016 was the last year that providers could begin to receive incentive payments.*** Providers who did not receive their first incentive payment by Program Year 2016 will not be able to apply for incentive payments in Program Years 2017-2021.

- Providers who enter the SLR will fall into three basic categories:

    1) Providers who are applying for the program on their own, without having been identified as group or clinic members or prequalified by DHCS,

    2) Providers who have been "prequalified" for the program by DHCS based on their Medicaid patient volumes in the prior calendar year, or

    3) Providers who have been previously identified as a member of a group or clinic by a group or clinic representative (note: groups can also be prequalified).

- Providers should keep in mind that they can take advantage of the eligibility of the group or clinic without being obligated to assign their incentive payments to the group or clinic. According to federal regulations, providers can assign their incentive payments to an employer or other entity with which they have a contract allowing the entity to bill for their professional services. This assignment must be voluntary and is done when registering in the CMS Registration and Attestation Site. Providers who do not take advantage of the eligibility of groups or clinics can register either on their own providing patient volume data from a different practice site, or on their own providing their individual practice volumes from the group or clinic. If providers choose the latter, according to federal regulations, they will prevent other providers in the group or clinic from using the group or clinic eligibility. Providers choosing this course will be required to speak with the SLR Help Desk to make sure that they fully understand their options.

- Providers who have been prequalified by DHCS will not need to enter patient volume data (Step 2: Eligibility) when applying. Although prequalified providers have been deemed to have met the 30 percent Medicaid volume threshold, Meaningful Use (MU) requirements must still be met in order to qualify.

Registering for the Medi-Cal Promoting Interoperability Program

Registration for providers is a two-step process.

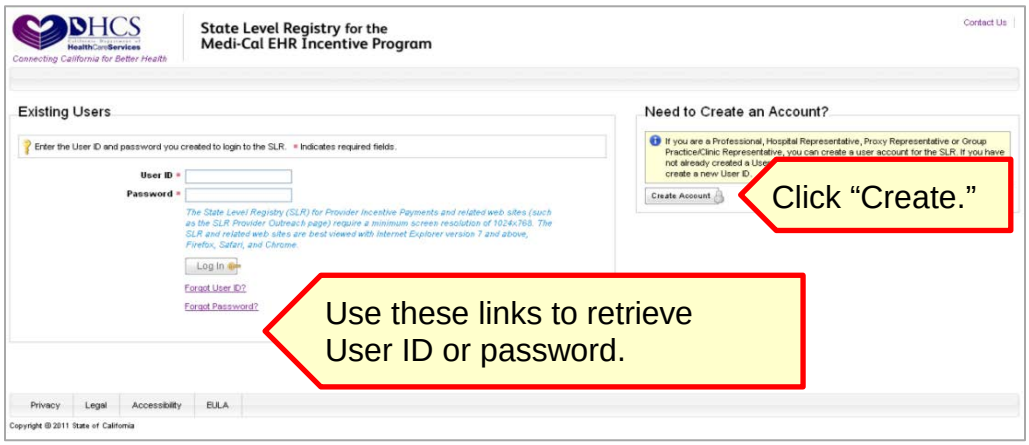
1. Providers must have already registered with the Centers for Medicare and Medicaid Services (CMS).

2. Providers must register with the California Department of Health Care Services via the State Level Registry (SLR).

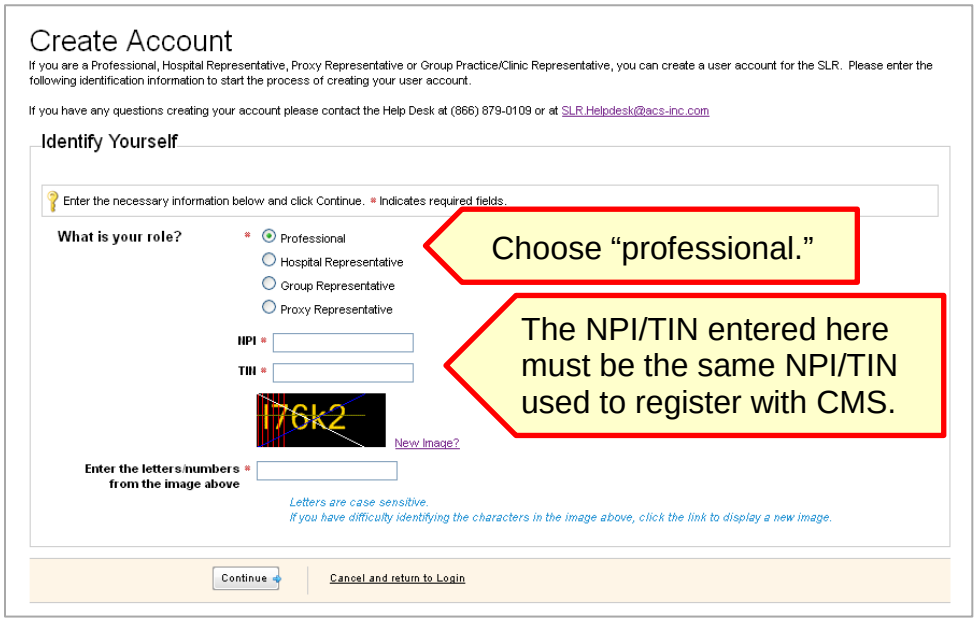
This Quick-Start Guide provides instructions for the SLR registration process.

Create an Account

To create an account on the SLR, visit http://ehr.medi-cal.ca.gov and click on "Create Account." If you do not know your user name or password, that information may be retrieved by using the "Forgot User ID?" or "Forgot Password?" links. The SLR Helpdesk is also available for assistance and can be reached by phone, (855) 649-7806, or emailing CASLRSupport@us.ibm.com.

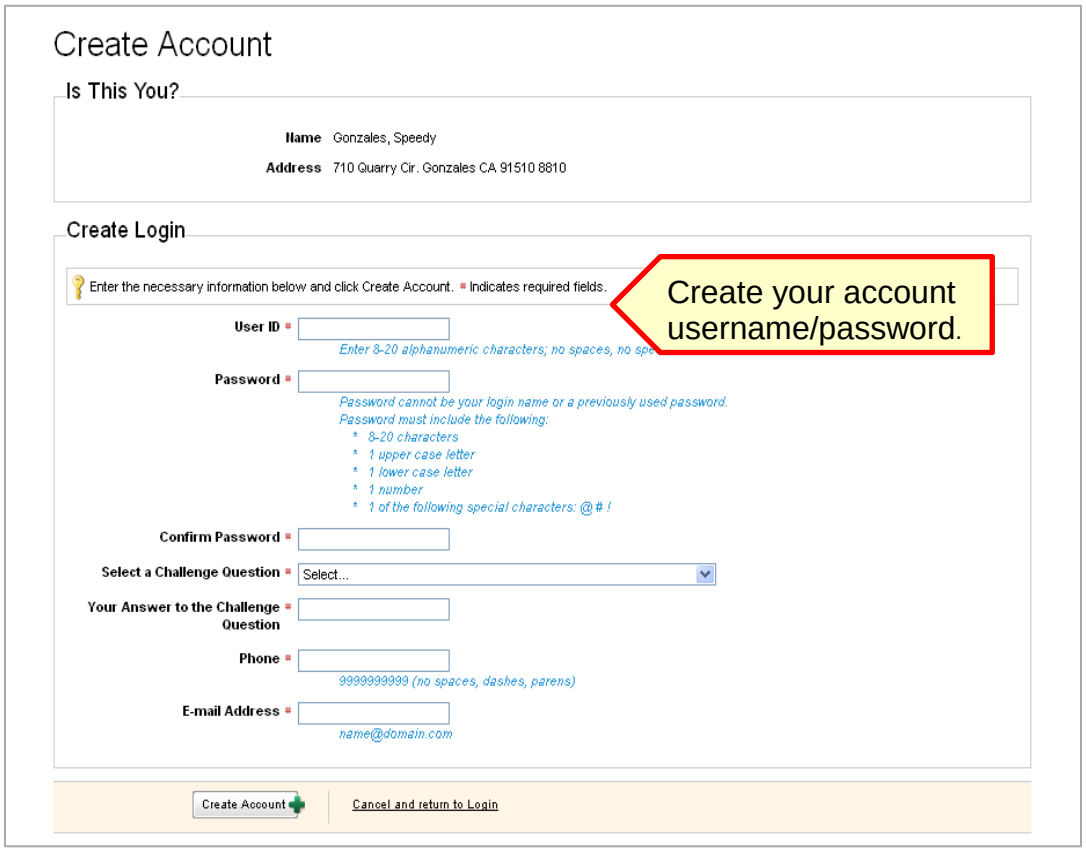


Choose the "Professional" role and enter your NPI and TIN. It is important to note that the NPI and TIN entered here must be the same NPI/TIN combination used to register with CMS.



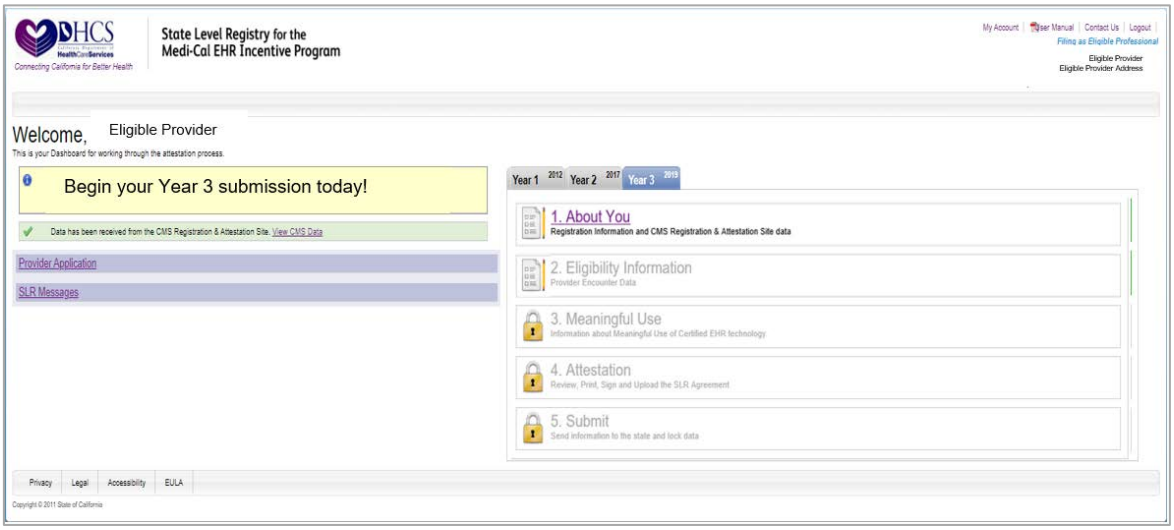
Upon clicking "Continue," you will be prompted to verify your name and address before you can complete your registration:


Create Account
Is This You?
Name Gonzales, Speedy
Address 710 Quarry Cir. Gonzales CA 91510 8810
Confirm information.
No, Go back
Yes, Continue

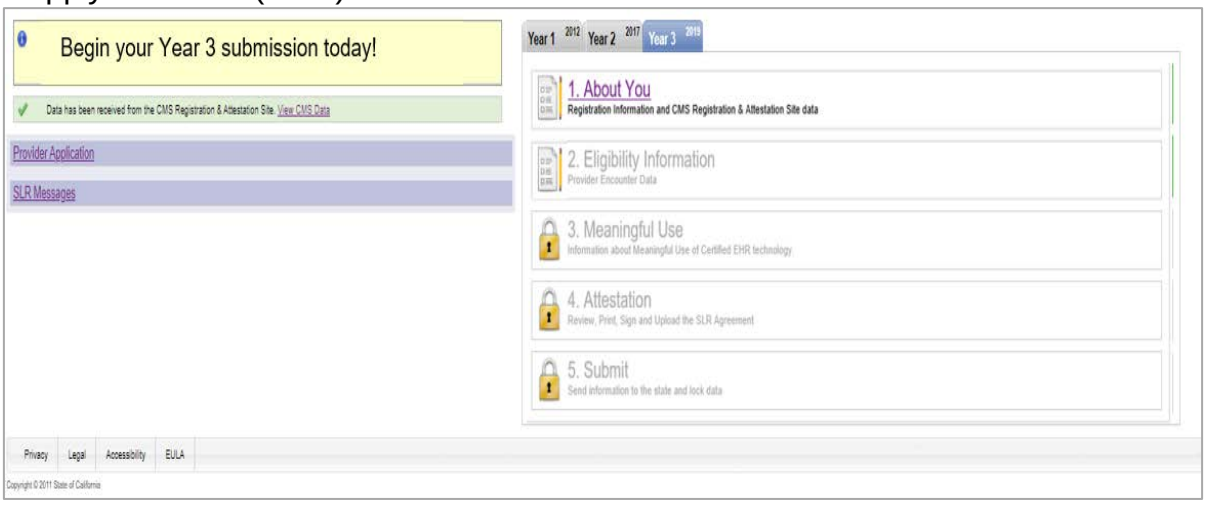

Create Account
Is This You?
Name Gonzales, Speedy
Address 710 Quarry Cir. Gonzales CA 91510 8810
Create Login
Enter the necessary information below and click Create Account. * Indicates required fields.
Create your account username/password.
User ID *
Password *
Password cannot be your login name or a previously used password.
Password must include the following:
* 8-20 characters
* 1 upper case letter
* 1 lower case letter
* 1 number
* 1 of the following special characters: @ # !
Confirm Password *
Select a Challenge Question *
Select...
Your Answer to the Challenge Question *
Phone *
9999999999 (no spaces, dashes, parens)
E-mail Address *
name@domain.com
Create Account
Cancel and return to Login

Dashboard

Upon login, you will be directed to the Dashboard where you can navigate each step of the application process. Each step must be completed before the next step is accessible.



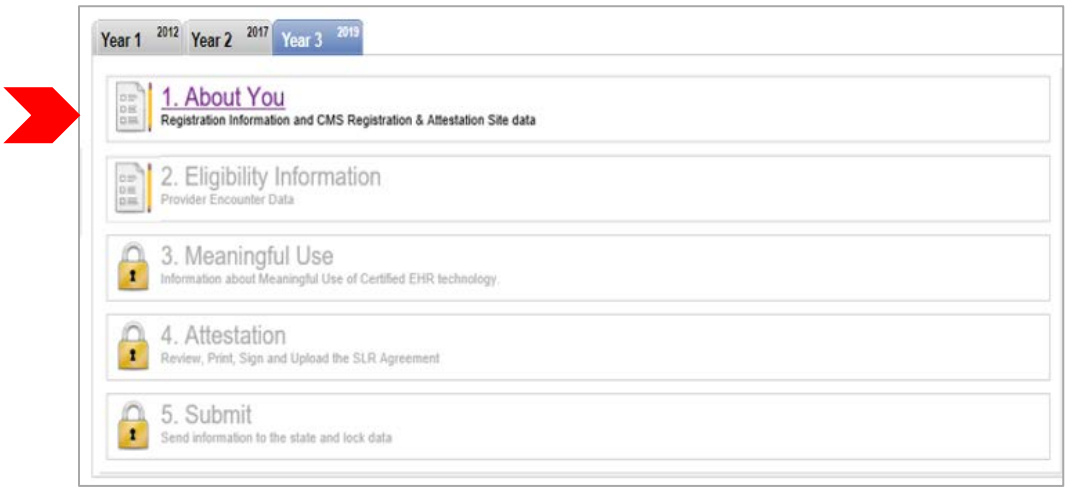
Please note that providers cannot apply for the current year until their application for the previous year has been reviewed (and subsequently approved or denied) by the state. The provider below has been approved by DHCS for Year 1(2012), 2(2017), and is able to apply for Year 3(2019).



Providers can access data from each year that they have participated in the program by clicking on the corresponding tabs on the Dashboard.

Step 1: About You

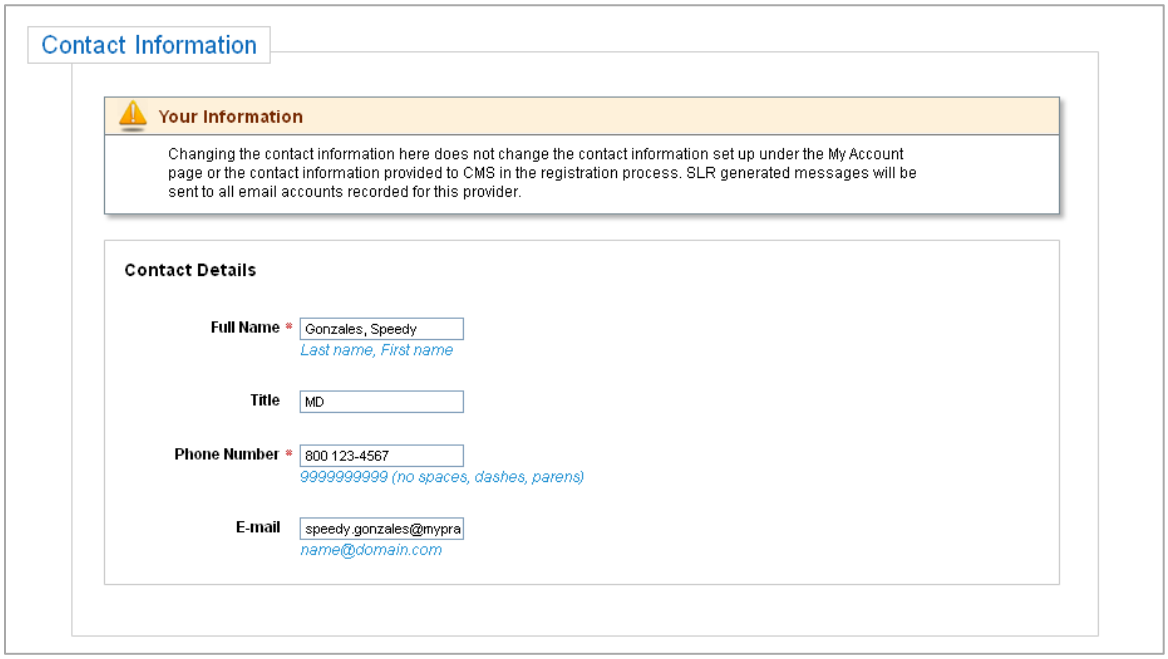
Step 1 in the SLR requires providers to enter contact information, license information, and group/clinic participation (if applicable).



Contact Information

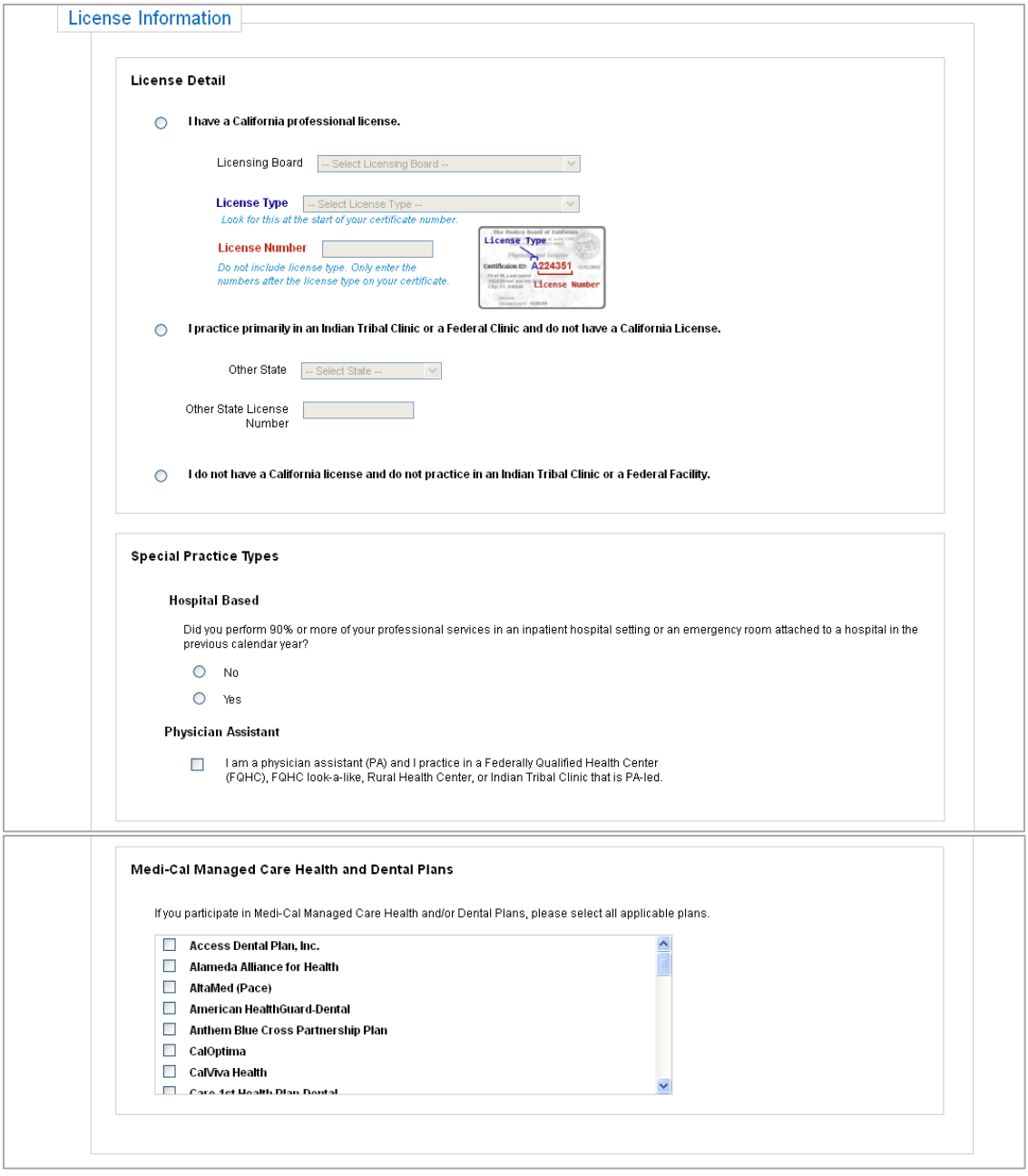
Enter the name and contact information for the contact person on the account.

For providers who have previously registered with Medi-Cal, this section will be pre-populated with the information entered from the previous year. This information should be reviewed and updated if the pre-populated information if it is no longer valid.



License Information

Enter your license information, special practice type(s), and Medi-Cal Managed Care Health or Medi-Cal Dental Plan affiliation(s).



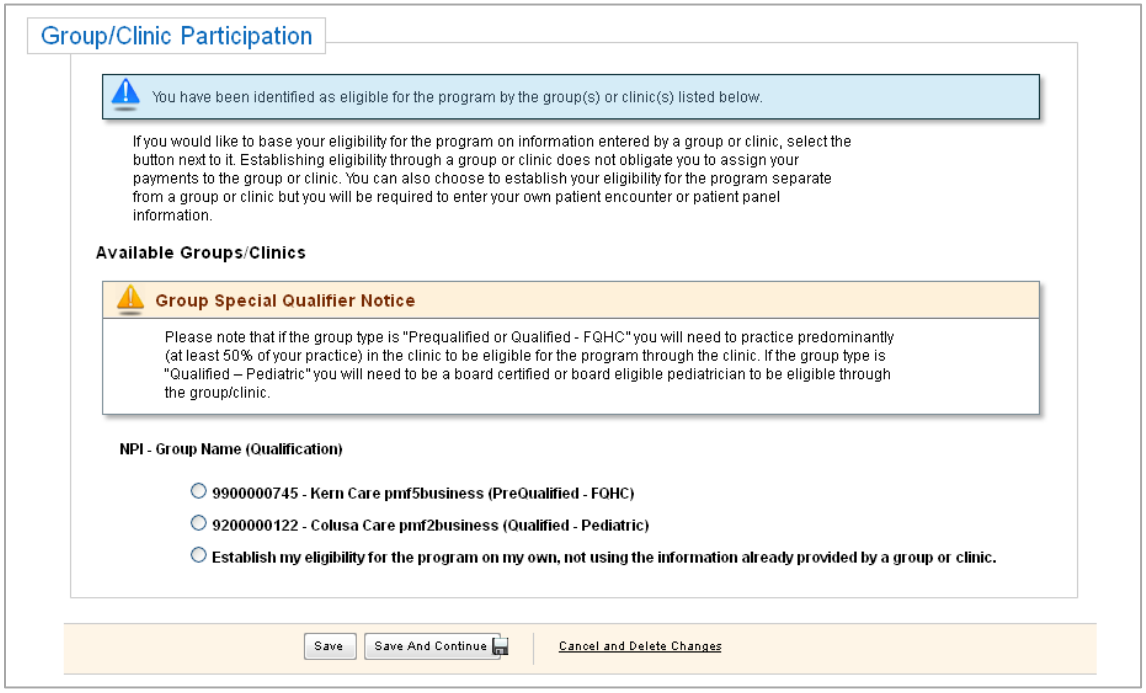
Group/Clinic Participation

The final part of Step 1 is selecting how you would like to participate in the program – with a group (if applicable) or on your own as an individual provider.

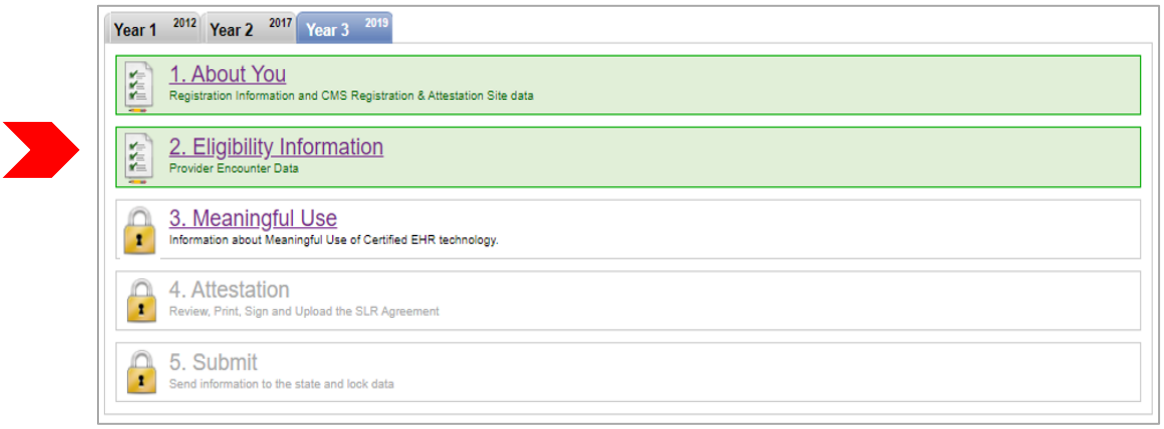
If you are part of a group/clinic, you will have the option to participate with your group/clinic and establish eligibility for the program using information entered by your group/clinic. Once the group/clinic representative creates an account and adds you as a member of their group/clinic, the group will be available for your selection as shown below. If you are part of multiple groups, all groups that you have been added to will be listed.

Documentation requirements for providers that are a part of a group/clinic are discussed in the Stage 3 MU requirements section.

Alternatively, you have the option not to participate with your group/clinic and instead establish eligibility on your own.



Step 2: Eligibility Information



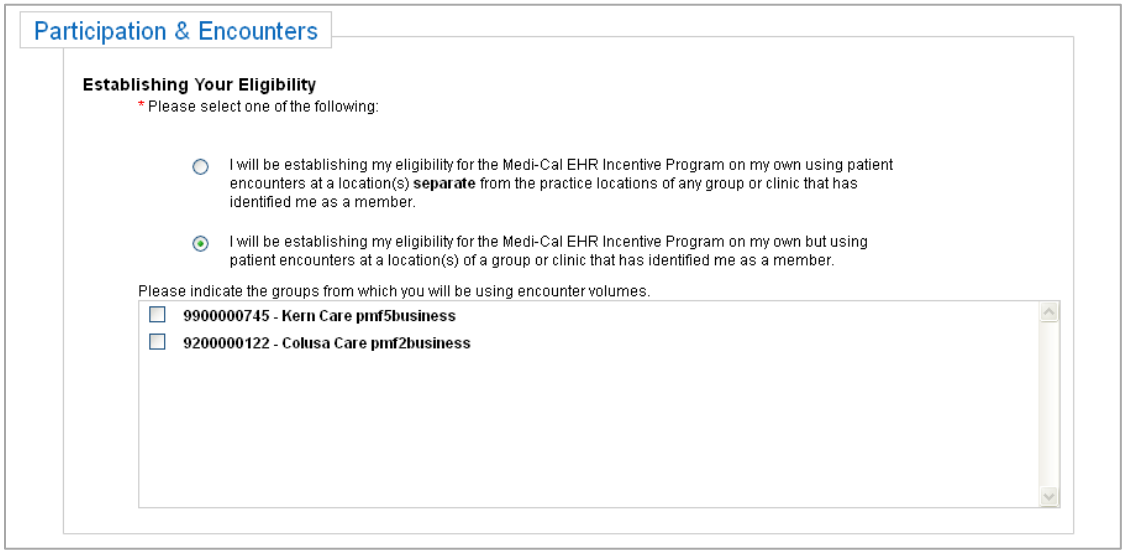
Participation & Encounters

Note: Prequalified providers and those who choose to establish eligibility as part of a group in Step 1 will not be asked to complete this step.

Providers who have been added to a group but are electing to establish eligibility on their own have the following options:

1. Use patient encounters that are not affiliated with a group/clinic that has identified them as a member, or
2. Use patient encounters that occurred at one or more of their group/clinic locations that has identified them as a member.

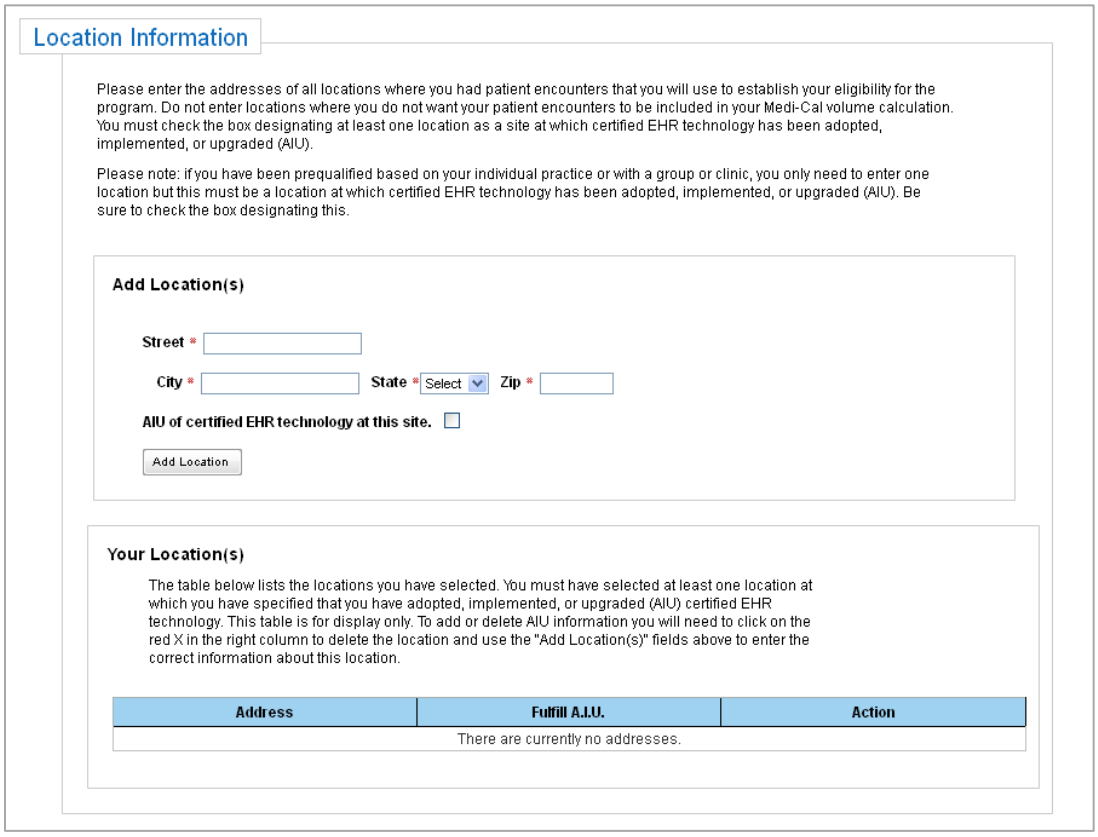
   Note: If a provider chooses option below, they will be required to specify the group/clinic from which they are using encounter volumes. This action will "close" the group and restrict other providers from using the group's volumes. Providers that choose this option will be instructed to contact the help desk at (855) 649-7806 before they can proceed with submitting their attestation.



Location Information

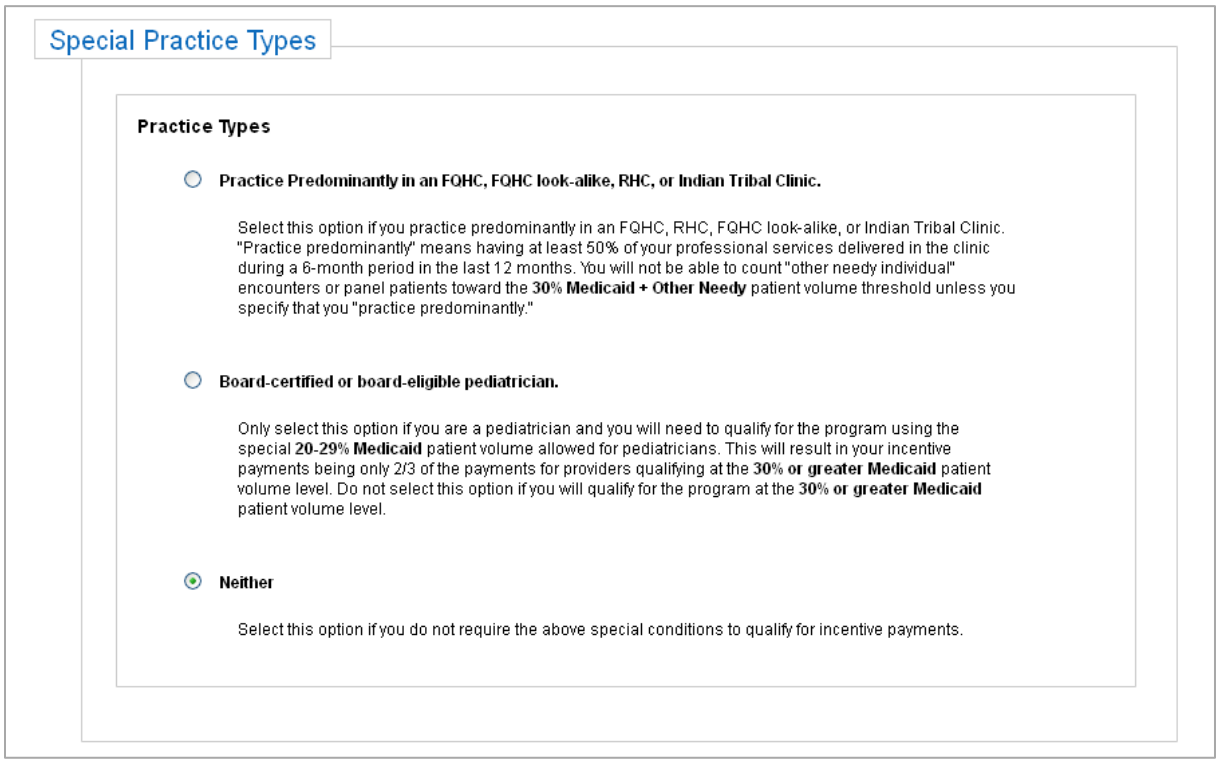
Enter the addresses of all locations where you had patient encounters that you will use to establish your eligibility for the program. Do not enter locations where you do not want your patient encounters to be included in your Medi-Cal volume calculation.

You must check the box designating at least one location as a site at which certified EHR technology is in use.



Special Practice Types

Selecting certain special practice types will affect the formulas used to calculate your eligibility.



- **Practice Predominantly FQHC, RHC, FQHC Look-Alike, or Indian Tribal Clinic.**
  Select this option if you practice predominantly in an FQHC, RHC, FQHC look-alike, or Indian Tribal Clinic. “Practice predominantly” means having at least 50 percent of your professional services delivered in the clinic during a 6-month period in the last 12 months. You will not be able to count “other needy individual” encounters or panel patients toward the **30 percent Medicaid + Other Needy** patient volume threshold unless you specify that you “practice predominantly.”

- **Board-certified or board-eligible pediatrician.**
  Only select this option if you are a pediatrician and you will need to qualify for the program using the special **20-29 percent Medicaid** patient volume allowed for pediatricians. This will result in your incentive payments being only 2/3 of the payments for providers qualifying at the **30 percent or greater Medicaid** patient volume level.

Provider's Patient Volumes

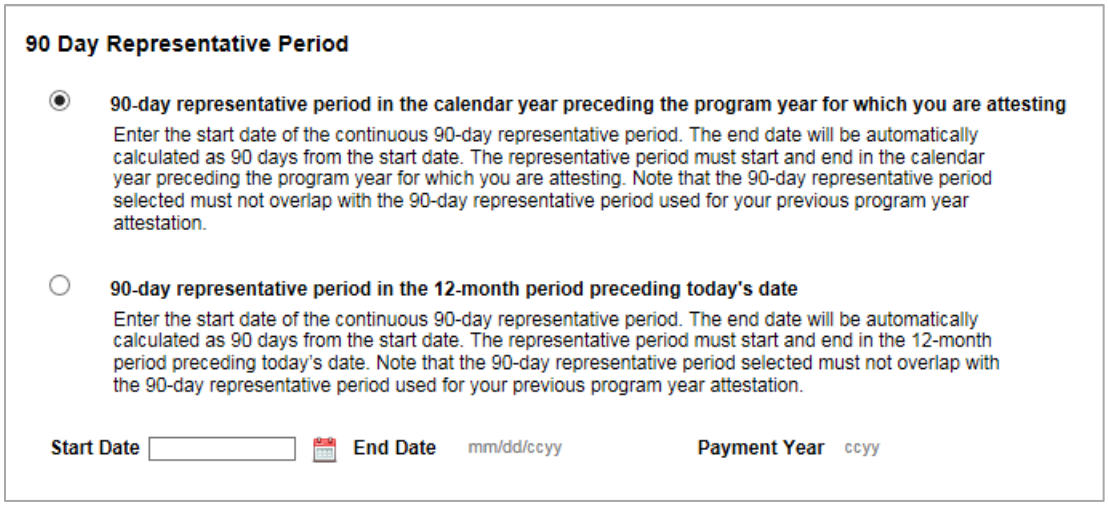
For providers who choose to establish eligibility as part of a group in Step 1, this data will be pre-populated with group/clinic volumes (entered by the group/clinic representative).

In each participation year (years 1 through 6) providers must show that they meet the minimum 30 percent Medicaid Encounter volume requirement (20 percent for pediatricians) within any 90-day period from the previous calendar year, **or** in the 12-months prior to attestation.

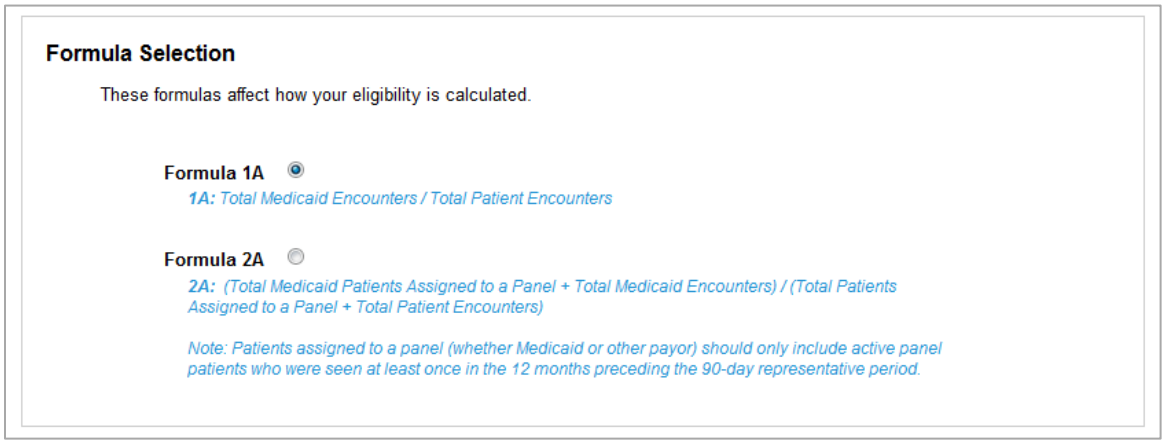
Providers must first choose the 90-day representative period from which patient volumes will be derived. There are two approaches available:

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.

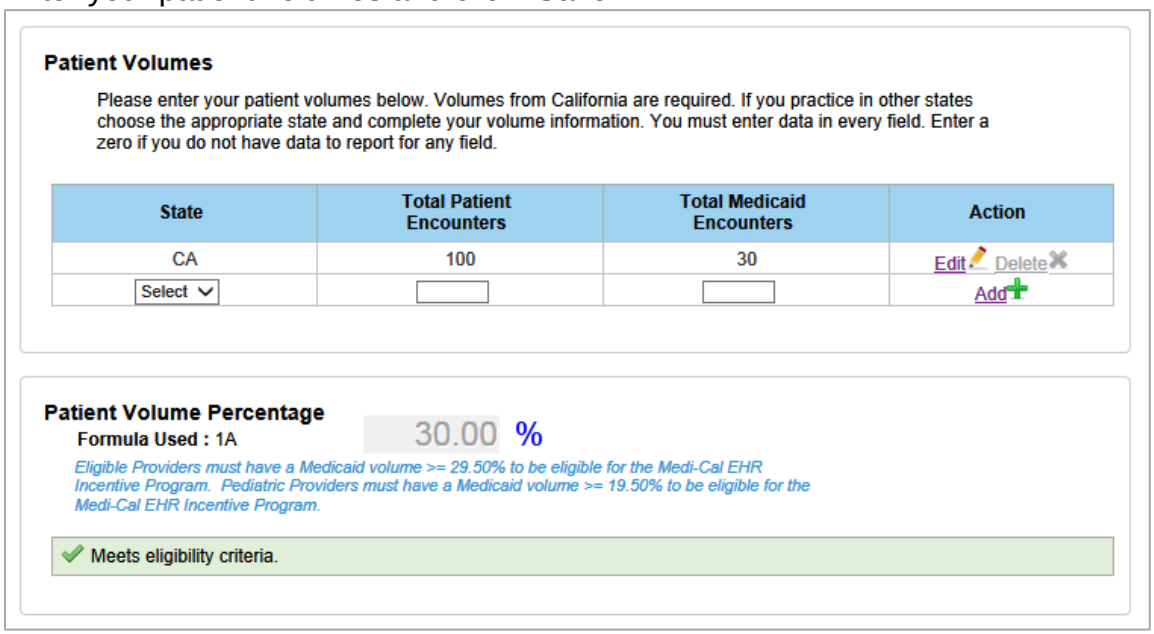
90-day Representative Period in the *12 months prior to attestation*:
The representative period must start and end in the 12-month period preceding the date that the provider submits their attestation. Note that the 90-day representative period selected must not overlap with the 90-day representative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



Choose the formula that you would like to use to calculate your eligibility:



Enter your patient volumes and click “Save”:

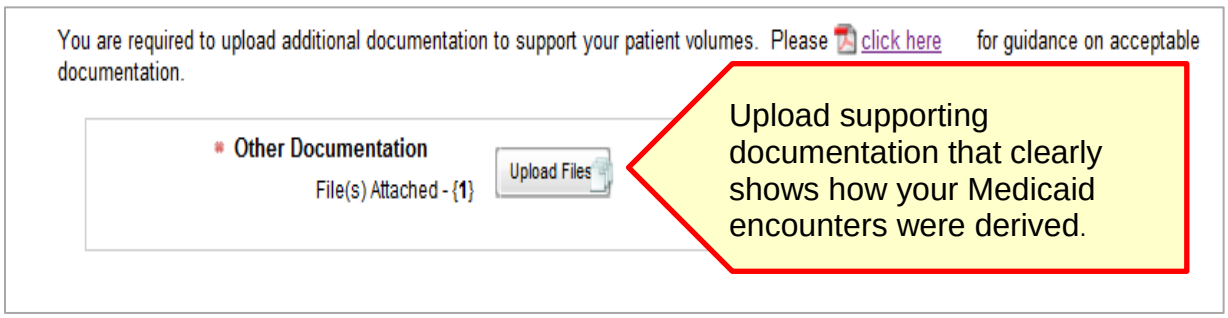


To qualify, providers must have a minimum of 29.5 percent Medicaid volumes (pediatricians can qualify for a reduced incentive payment with 19.5 percent-29 percent Medicaid volumes). Providers who practice predominantly in an FQHC, RHC, FQHC Look-Alikes, or Indian Tribal Clinics can qualify with Medicaid + Other Needy Individual volumes.

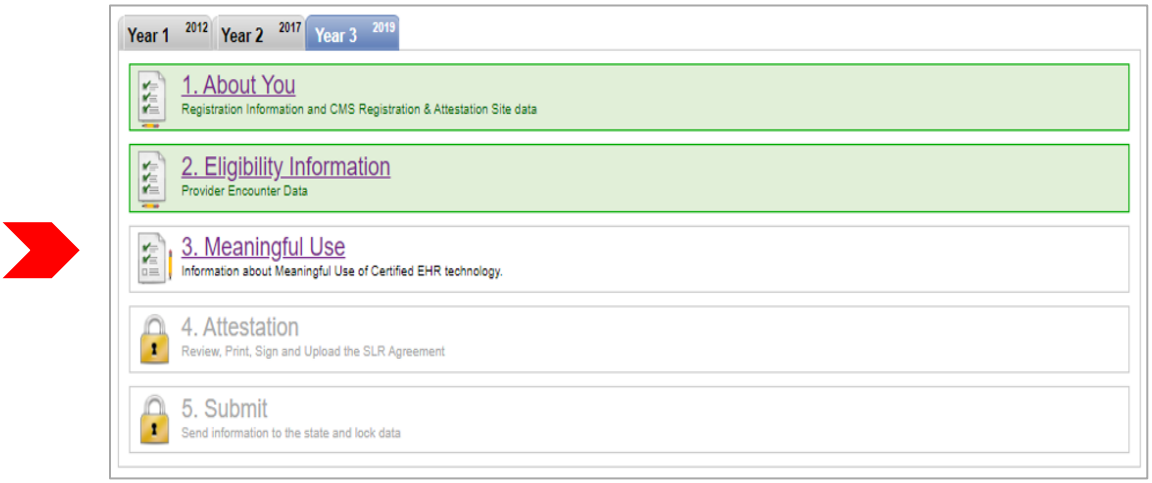
Patient Volumes – Supporting Documentation

In order to assist in the verification of the provider’s Medicaid encounter volumes, providers are required to upload supporting documentation from an auditable data source (such as the provider’s EHR technology or practice management system) that clearly shows the Medicaid encounters that occurred during the selected 90-day representative period. A summary page is also required in order to describe how to interpret the documentation.

For details on what DHCS deems acceptable documentation, please reference Medi-Cal Backup Documentation Requirements.



Step 3: Meaningful Use (MU)



Program Year 2016 was the last year that a provider could *begin* receiving incentive payments and attest to AIU. AIU is no longer an option and all providers are required to attest to MU.

MU Stage 3

Beginning in 2019, DHCS requires that documentation for meaningful use be uploaded to the State Level Registry 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. 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.

The documentation for individual providers participating in a group/clinic can be uploaded into the group/clinic SLR account, as long as separate MU data is provided for each

professional. In the case of a group/clinic, the SRA documentation does not have to be specific for each professional. Providers in a group/clinic should speak with their group/clinic representative regarding uploading MU documentation into the group/clinic SLR account.

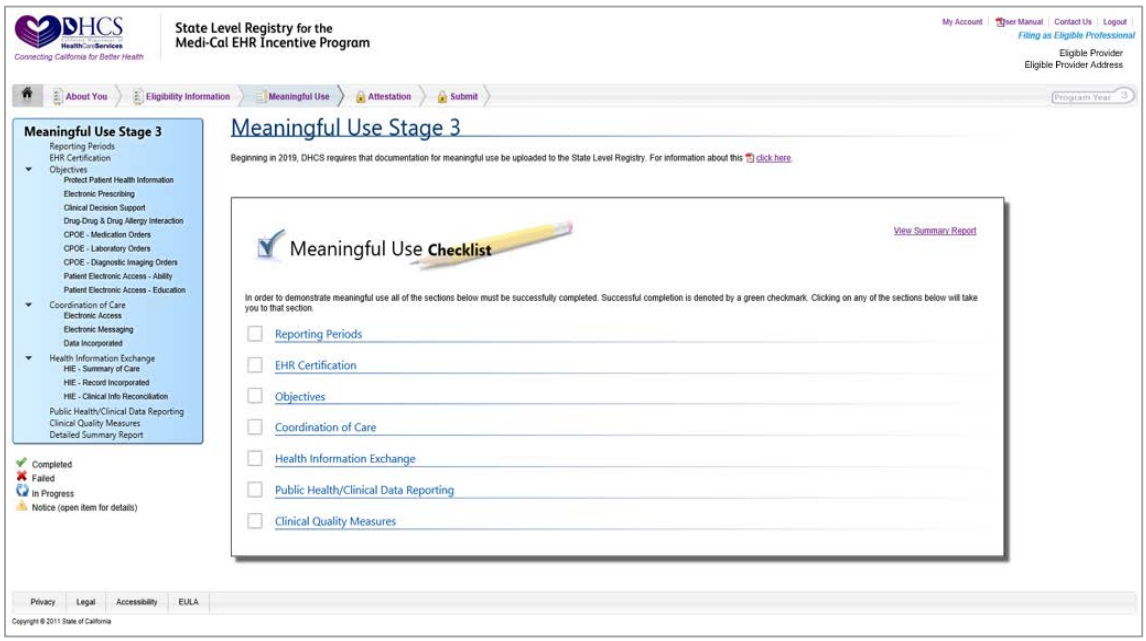
Stage 3 MU Requirements

In order to demonstrate meaningful use, all of the sections in the navigation window must be successfully completed.

MU Section	Stage 3 Provider Requirements
MU Reporting Period	Choose a minimum 90-day meaningful use reporting period from within the current calendar year.
CQM Reporting Period	1st year MU- Choose a minimum 90-day CQM reporting period from within the current calendar year. After Year 1 MU – the CQM Reporting Period is the entire calendar year.
EHR Certification	Enter the CMS EHR Certification ID for the EHR technology used to fulfill MU.
Objectives	Pass all 8 Objectives. There are 20 measures total. Of those, providers must pass two of the three Coordination of Care measures, two of the three HIE measures, and two of the five Public Health measures.
Public Health Reporting	Pass at least two out of five measures or attest to all five measures without failing any measure. Exclusions do not count as failing.
Clinical Quality Measures (CQMs)	6 CQMs relevant to the scope of practice must be selected. At least one must be a relevant outcome measure. If no outcome measure is relevant, at least one high-priority measure must be selected. If there are no outcome or high-priority measures relevant to the EPs scope of practice, 6 other relevant CQMs must be selected. Zeroes may be entered in numerators and denominators.
Documentation Requirements	Upload MU documentation.

Stage 3 MU Progress

The left-hand navigation menu will guide you through each MU requirement. This menu can be used to access and enter information in the MU screens prior to entering MU and CQM reporting periods. Choosing “Save & Continue” on each screen will bring you to the next item in the navigation menu. Alternately, you may skip around by clicking items in the navigation menu.



The following icons will help guide you in your workflow:

Key	
	Passed MU Requirement
	Failed MU Requirement
	Notice (open item for specific notice details)
	In Progress

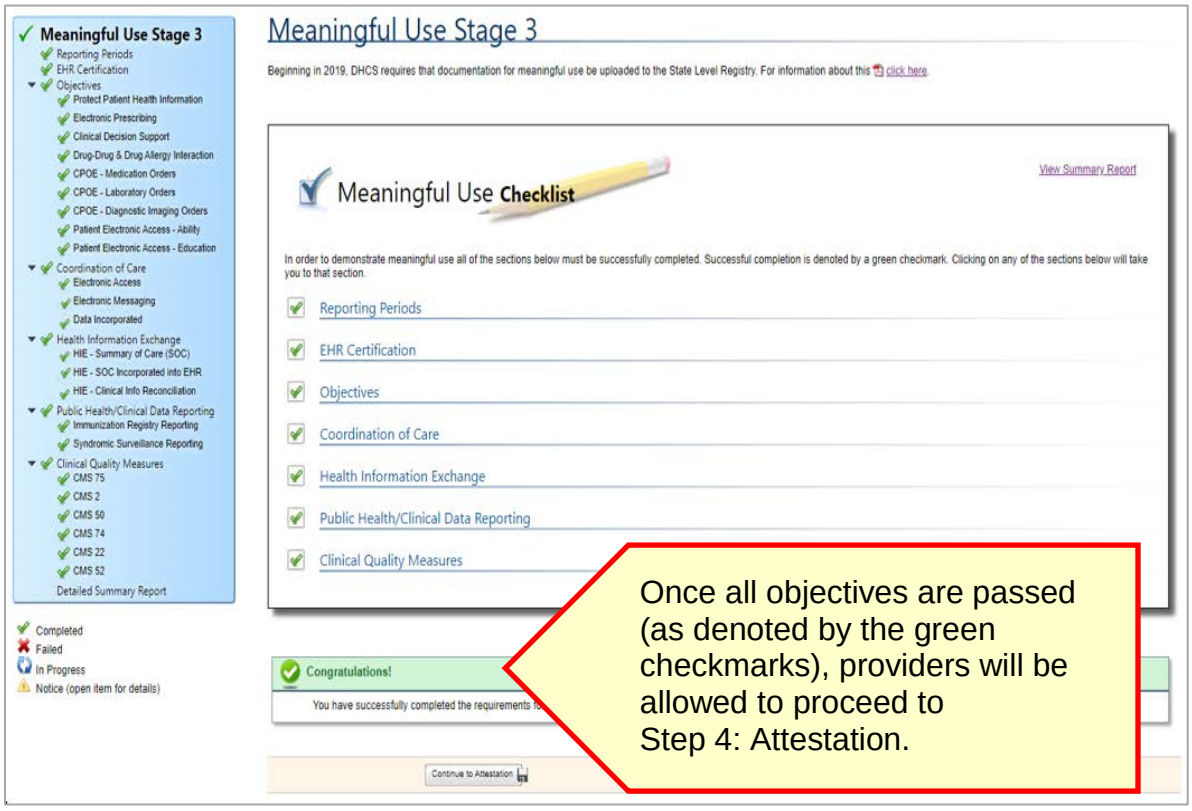
Note: Providers will not be able to submit an attestation unless all MU requirements have been met. Items that are in “in progress” or “failed” status will prohibit the provider from completing an attestation.

MU Checklist and Summary

At any point during the process, you can click on the “Detailed Summary Report” link at the bottom of the navigation menu to access a PDF report that shows your entries for each section.

Once all MU data is complete and objectives are passed (as denoted by ), you will be able to proceed to Step 4: Attestation. You will not be able to proceed if any MU items have been failed (as denoted by ) as this indicates that you have not met MU requirements.

Please note: You may pass an objective (such as Coordination of Care) even if you have failed one or more of the measures of that objective.



Reporting Periods

In Program Year 2019, all providers are able to use a minimum 90-day MU reporting period. Although providers are only required to use a 90-day reporting period, this period can be edited to be longer than 90-days by manually entering the end date in the corresponding field. All reporting periods must fall within the current calendar year and be less than or equal to a year in length. In this case, reporting periods for Program Year 2019 must fall within the 2019 calendar year.

For Program Year 2020, all providers will be able to use a minimum 90-day MU reporting period for both MU objectives and CQMs.

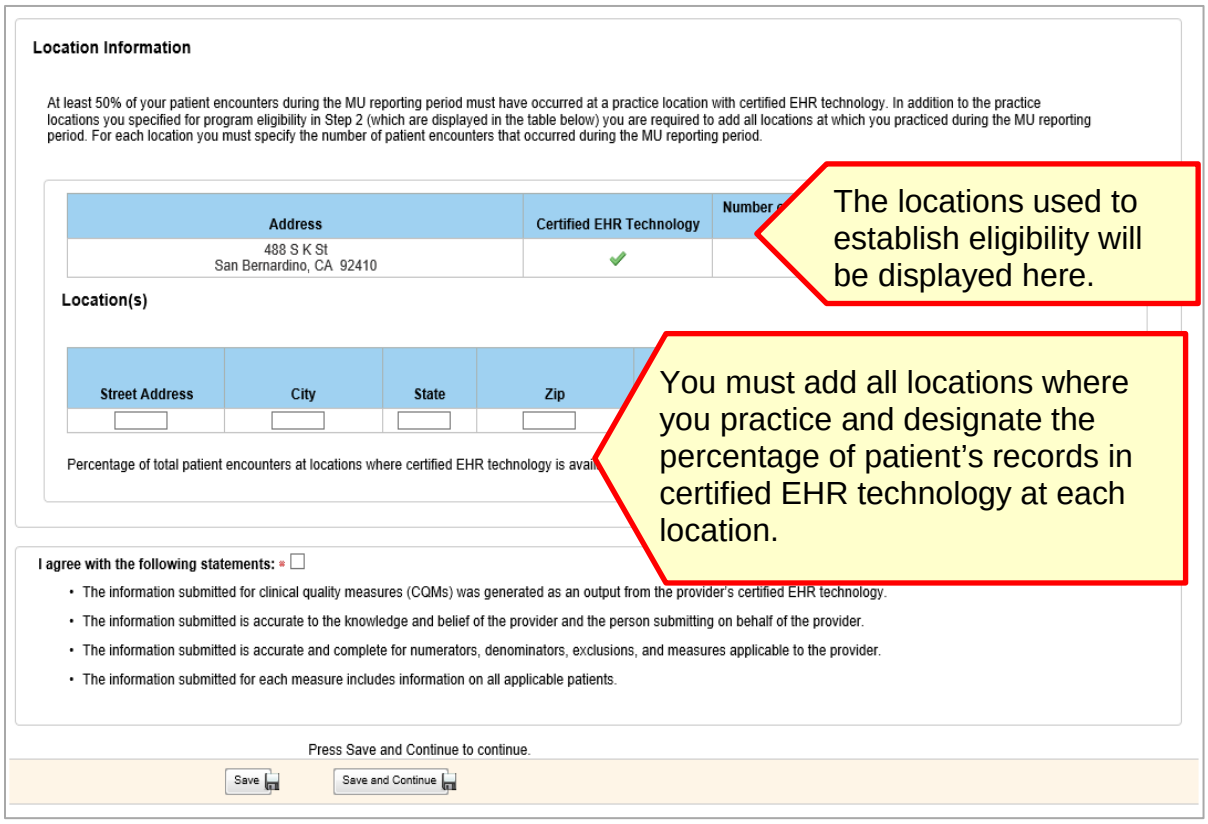
MU Reporting Period

CQM Reporting Period

For Program Year 2019, providers reporting MU for the first time are required to choose a minimum 90-day CQM Reporting Period. This period can be edited to be longer than 90-days by manually entering the end date in the corresponding field. The reporting period must fall within the current calendar year. Providers who have previously reported MU are required to use the full calendar year as the CQM reporting period

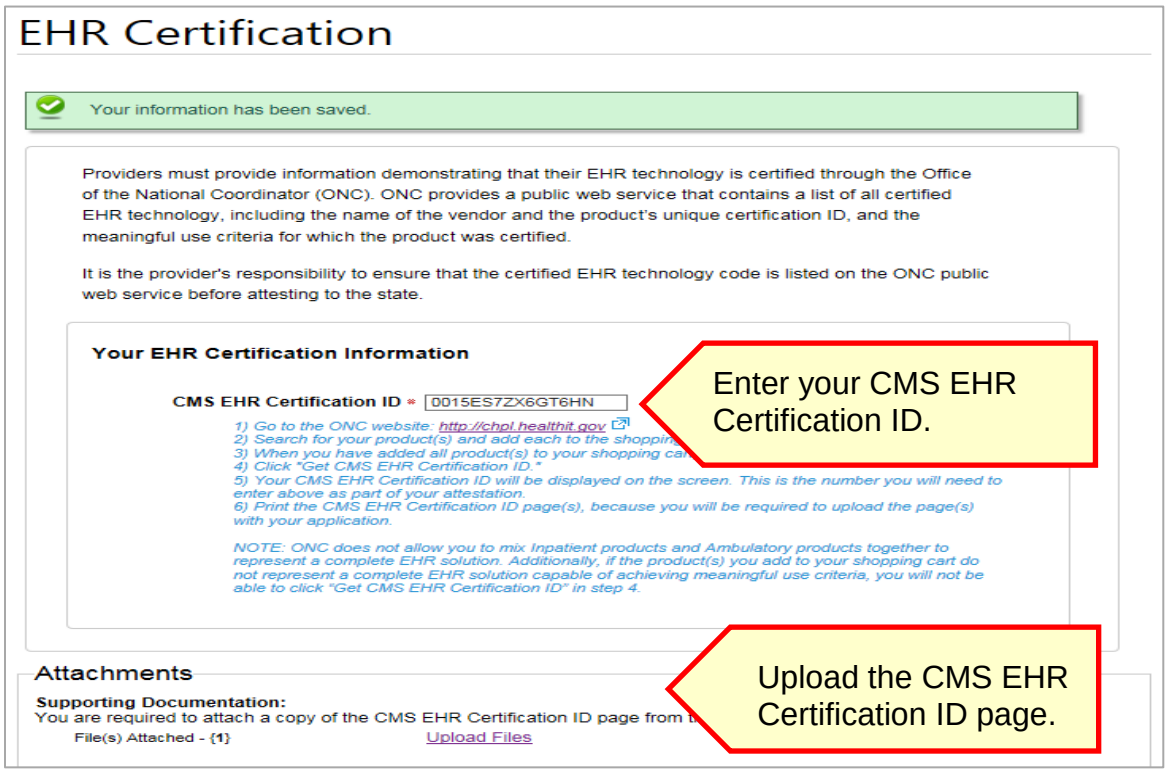
For Program Year 2020, all providers are required to choose a minimum 90-day CQM reporting period.

Location Information



EHR Certification

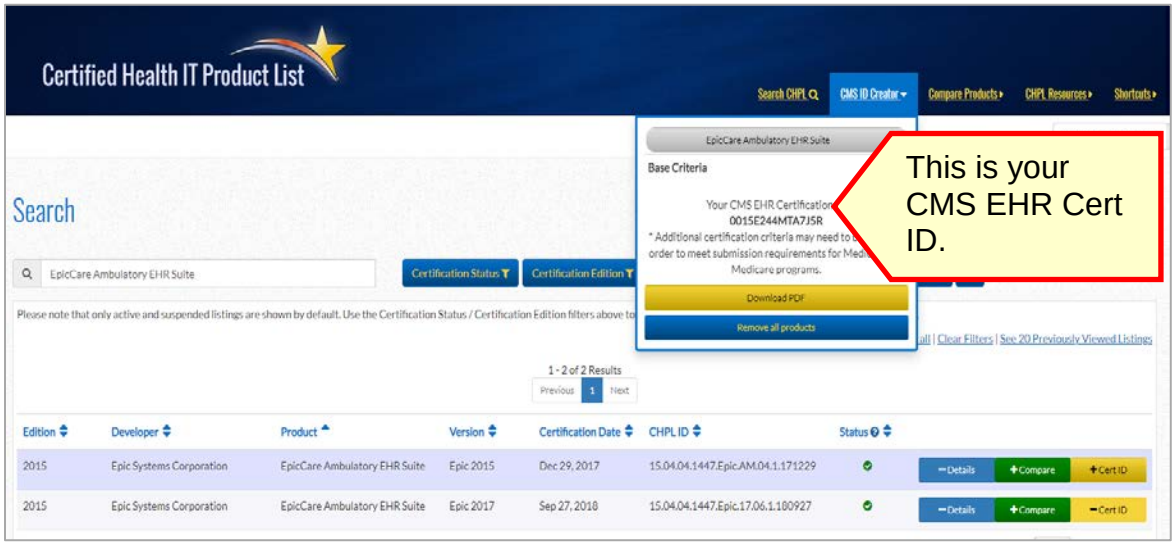
Enter the CMS EHR Certification ID for the certified technology used to demonstrate MU. A combination of 2014/2015 CEHRT or a 2015 CEHRT is acceptable to meet Stage 3 MU requirements. The combination 2014/2015 CEHRT or 2015 CEHRT must be implemented by the first day of the EHR reporting period and it must be a certified by the last day of the MU reporting period.



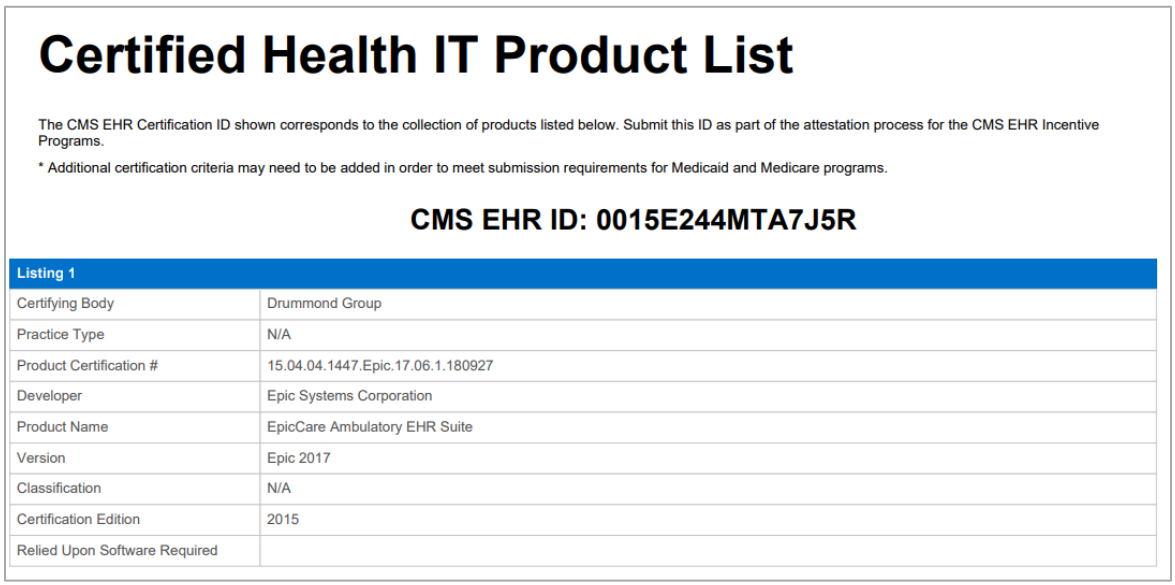
How to find your CMS EHR Certification ID:

1) Go to the ONC website: https://chpl.healthit.gov
2) Enter the product(s) name(s) and click "Browse all." Search results may be filtered by certification status, edition, criteria, and/or other parameters.
3) After selecting all product(s), click the "+ Cert ID" button to retrieve the ID.
4) The CMS EHR Certification ID will be displayed on the screen. This is the number needed to enter above as part of your attestation.
5) Click the "Download PDF" button below your EHR Certification ID number and upload a copy of this page to your SLR application.

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.



The Certified Health IT Product list is the page that is required to be uploaded into the SLR.



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.

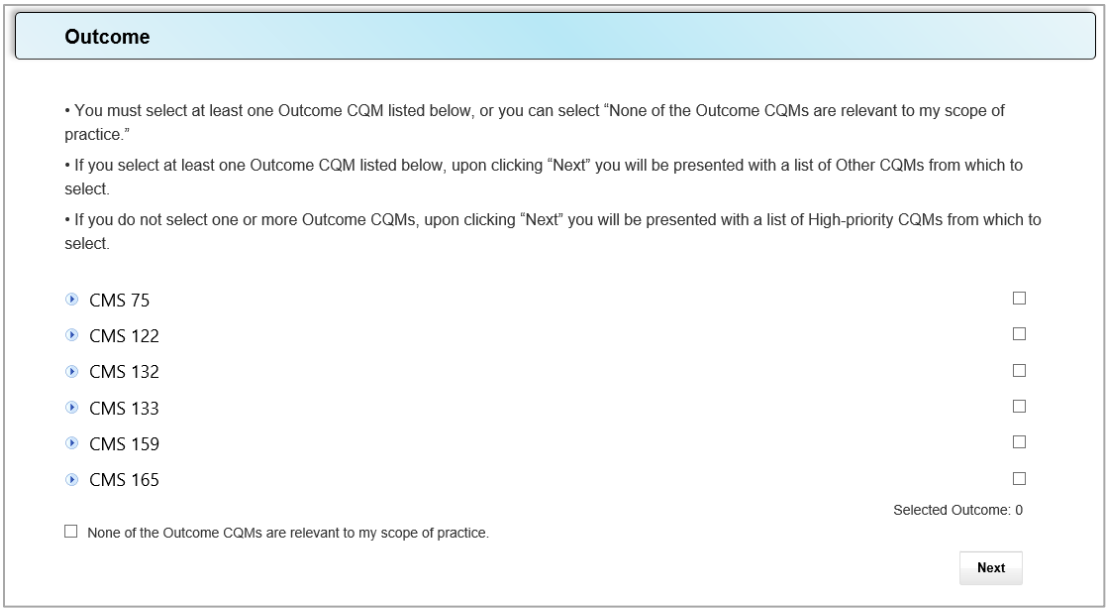
CMS EHR ID: 0015E244MTA7J5R

Listing 1	
Certifying Body	Drummond Group
Practice Type	N/A
Product Certification #	15.04.04.1447.Epic.17.06.1.180927
Developer	Epic Systems Corporation
Product Name	EpicCare Ambulatory EHR Suite
Version	Epic 2017
Classification	N/A
Certification Edition	2015
Relied Upon Software Required	

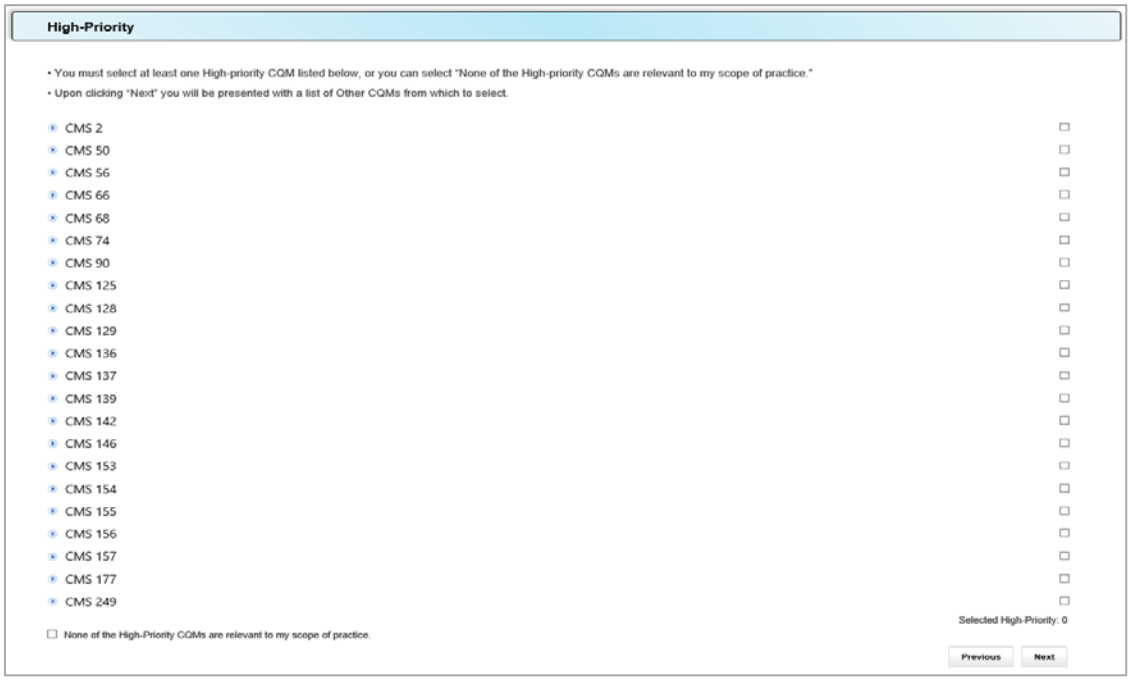
CQMs

For Program Year 2019, EPs are required to report on at least one outcome measure. If there are not any outcome measures that are relevant to the EP's scope of practice, the SLR will display a list of high-priority CQMs that may be selected. If none of the outcome or high-priority measures are relevant, the EP will then be able to select from a list of the remaining CQMs. These screens are shown in more detail below.

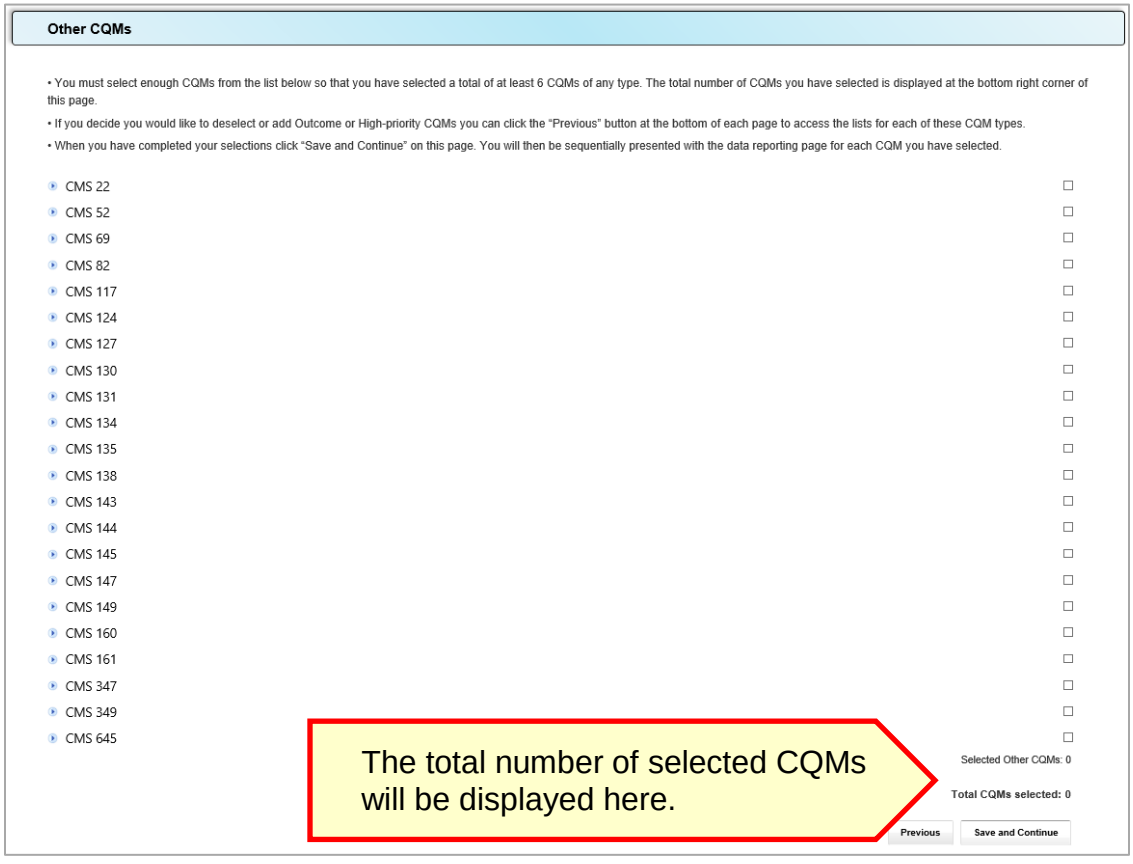
Providers are first presented with a list of Outcome CQMs. One or more Outcome CQMs may be selected from the list below. The provider also has the option to select that none of the Outcome CQMs are relevant to their scope of practice before clicking "Next."



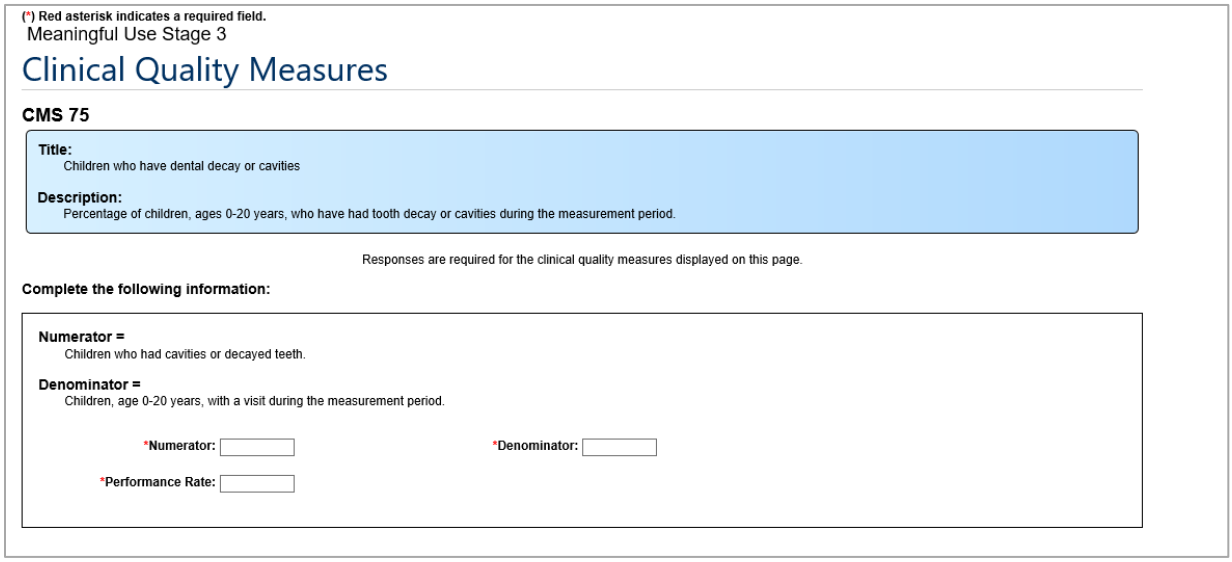
If the provider indicates that none of the Outcome CQMs are relevant, the SLR will display the list of High-priority CQMs. The provider must select at least one High-priority CQM or indicate that none of the High-priority CQMs are relevant to their scope of practice before clicking "Next."



If none of the Outcome or High-Priority CQMs are relevant to the provider's scope of practice, a list of all Other CQMs will be displayed. The provider can then select 6 or more relevant CQMs. The total number of CQMs selected is displayed at the bottom right of the Other CQM page.

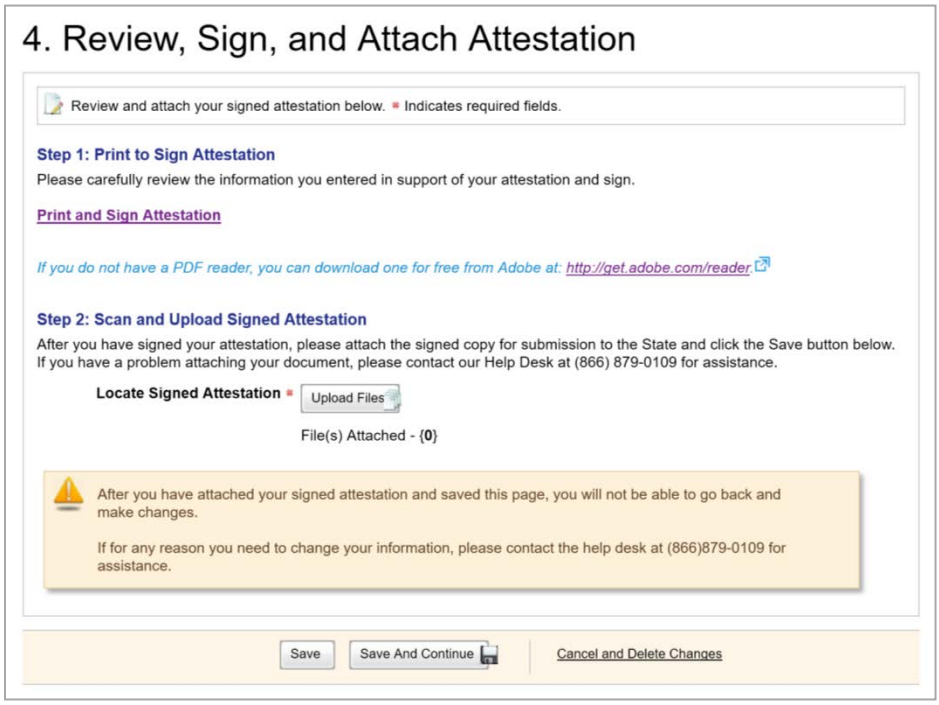


Prior to attestation, providers will have the ability to view the previous CQM screens by selecting the “previous” button. This allows for review of the previous CQM lists so that additional CQMs may be deselected or added. When all CQMs have been selected, click “Save and Continue.” The following pages will then collect the data for each selected CQM.



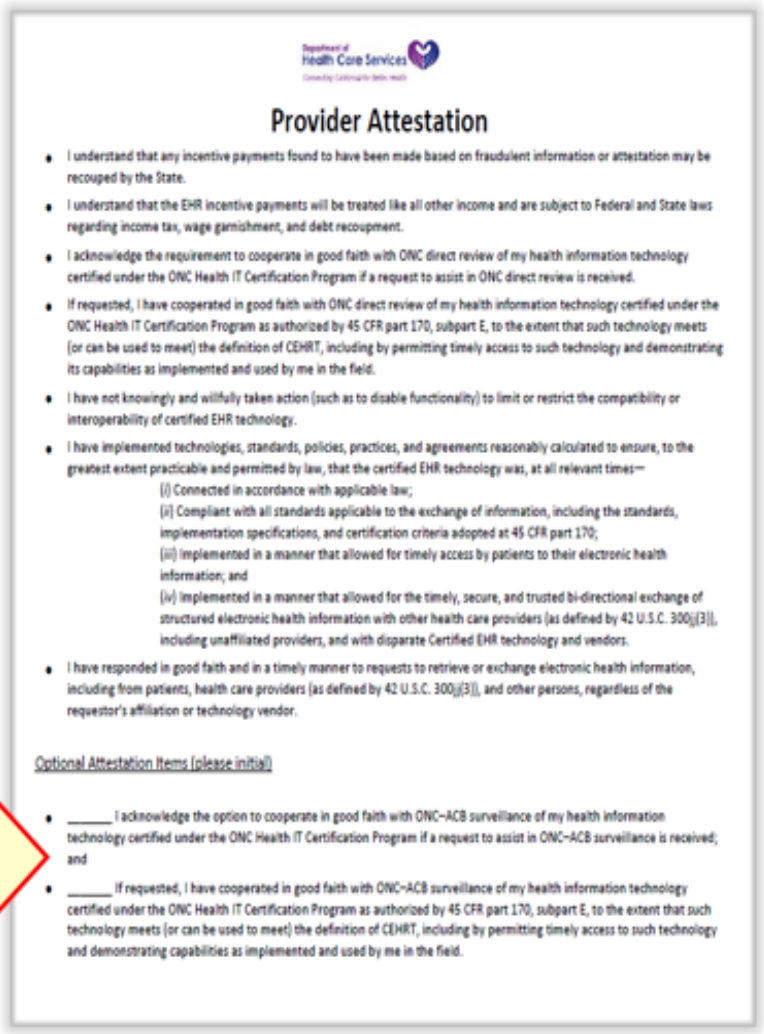
Step 4: Attestation

Providers will be required to print, physically sign, and upload their Provider Attestation.



Please note: Providers that have received technical assistance from the California Technical Assistance Program (CTAP) may have an additional signature section on their attestation acknowledging receiving this service. Signing this section is voluntary and does not affect a provider's eligibility for the Medi-Cal Promoting Interoperability Program.

On the final pages of the Provider Attestation, providers are advised that any incentive payments based on fraudulent information may be subject to recoupment. Providers also acknowledge that, should additional information be needed, that responses will be returned in a timely manner. As noted below, two areas on the attestation are optional. Initials are not required unless the provider decides to do so.



Department of Health Care Services

Provider Attestation

- I understand that any incentive payments found to have been made based on fraudulent information or attestation may be recouped by the State.
- I understand that the EHR incentive payments will be treated like all other income and are subject to Federal and State laws regarding income tax, wage garnishment, and debt recoupment.
- I acknowledge the requirement to cooperate in good faith with ONC direct review of my health information technology certified under the ONC Health IT Certification Program if a request to assist in ONC direct review is received.
- If requested, I have cooperated in good faith with ONC direct review of my health information technology certified under the ONC Health IT Certification Program as authorized by 45 CFR part 170, subpart E, to the extent that such technology meets (or can be used to meet) the definition of CEHRT, including by permitting timely access to such technology and demonstrating its capabilities as implemented and used by me in the field.
- I have not knowingly and willfully taken action (such as to disable functionality) to limit or restrict the compatibility or interoperability of certified EHR technology.
- I have implemented technologies, standards, policies, practices, and agreements reasonably calculated to ensure, to the greatest extent practicable and permitted by law, that the certified EHR technology was, at all relevant times—
  (i) Connected in accordance with applicable law;
  (ii) Compliant with all standards applicable to the exchange of information, including the standards, implementation specifications, and certification criteria adopted at 45 CFR part 170;
  (iii) Implemented in a manner that allowed for timely access by patients to their electronic health information; and
  (iv) Implemented in a manner that allowed for the timely, secure, and trusted bi-directional exchange of structured electronic health information with other health care providers (as defined by 42 U.S.C. 300jj(3)), including unaffiliated providers, and with disparate Certified EHR technology and vendors.
- I have responded in good faith and in a timely manner to requests to retrieve or exchange electronic health information, including from patients, health care providers (as defined by 42 U.S.C. 300jj(3)), and other persons, regardless of the requestor's affiliation or technology vendor.

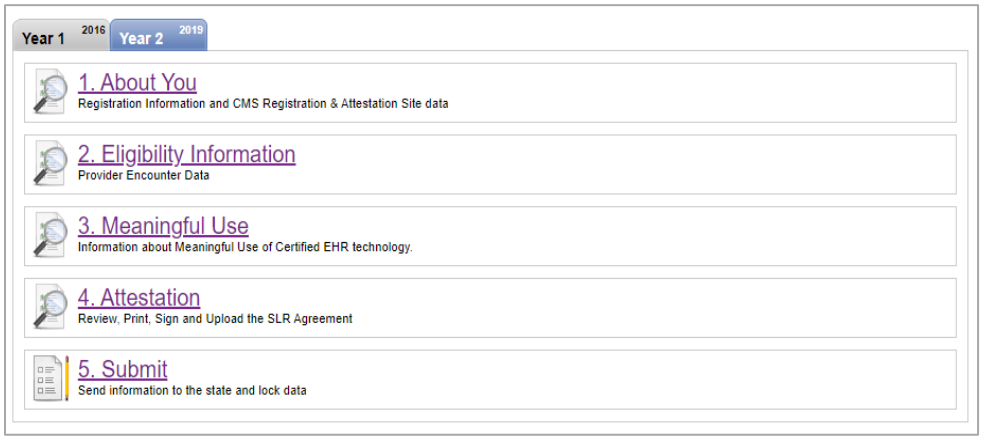
Optional Attestation Items (please initial)

- _____ I acknowledge the option to cooperate in good faith with ONC-ACB surveillance of my health information technology certified under the ONC Health IT Certification Program if a request to assist in ONC-ACB surveillance is received; and
- _____ If requested, I have cooperated in good faith with ONC-ACB surveillance of my health information technology certified under the ONC Health IT Certification Program as authorized by 45 CFR part 170, subpart E, to the extent that such technology meets (or can be used to meet) the definition of CEHRT, including by permitting timely access to such technology and demonstrating capabilities as implemented and used by me in the field.

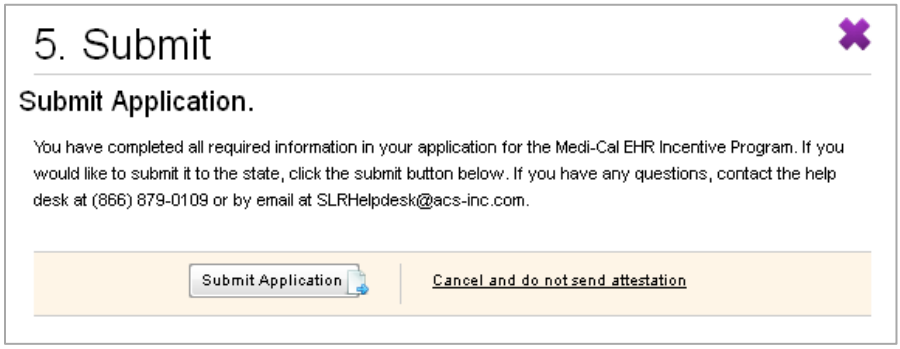
Please note: The "optional attestation items" are in fact optional. Initials are not required.

Once the provider uploads and saves the attestation, the previous steps become un-editable and the account will be in view-only mode.

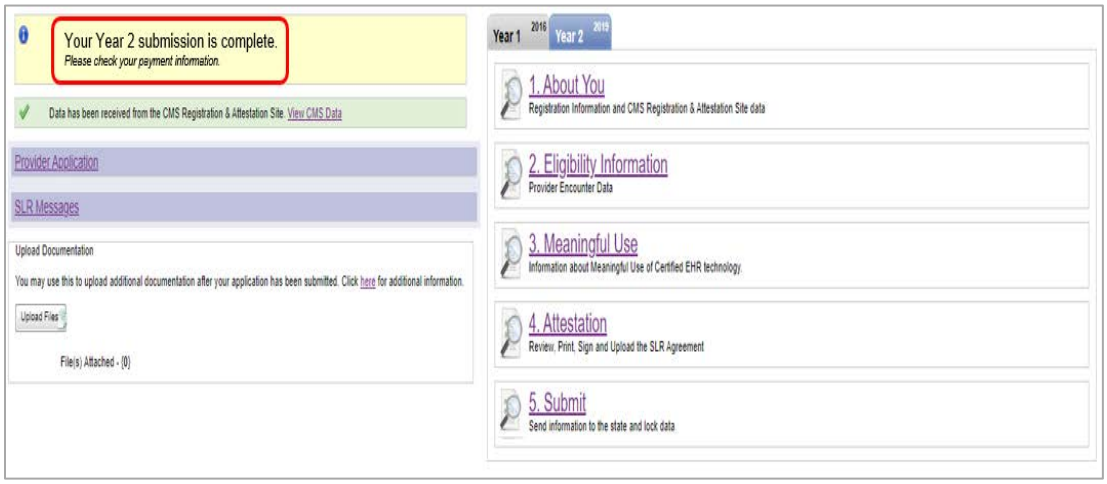
Step 5: Submit



The final step in the application process is submitting the attestation:



Upon clicking "Submit Application," you will receive an email confirmation that your attestation has been sent to the state. After submission, your account and data will be available in view-only mode.



Should you wish to upload additional documents to your account after submission, you can do so by clicking on the "Upload Files" button on the Dashboard.