State Level Registry (SLR) Quick Start Guide for Providers

Program Years 2019 - 20
## CONTENTS

### INTRODUCTION

Registering for the Medi-Cal Promoting Interoperability Program ................................. 4

Create an Account ................................................................................................................. 5

**Dashboard** ........................................................................................................................ 7

**Step 1: About You** ............................................................................................................. 8

- Contact Information ............................................................................................................. 8
- License Information .............................................................................................................. 9
- Group/Clinic Participation ................................................................................................. 10

**Step 2: Eligibility Information** .......................................................................................... 11

- Participation & Encounters ................................................................................................. 11
- Location Information .......................................................................................................... 12
- Special Practice Types ....................................................................................................... 13
- Provider’s Patient Volumes ................................................................................................. 14
- Patient Volumes – Supporting Documentation ................................................................. 15

**Step 3: Meaningful Use (MU)** ............................................................................................ 16

- MU Stage 3 ........................................................................................................................ 16
- Stage 3 MU Requirements ................................................................................................. 17
- Stage 3 MU Progress .......................................................................................................... 18
- MU Checklist and Summary ............................................................................................. 18
- Reporting Periods .............................................................................................................. 19
  - MU Reporting Period ..................................................................................................... 20
  - CQM Reporting Period ................................................................................................. 20
  - Location Information ...................................................................................................... 21
  - EHR Certification .......................................................................................................... 22
  - CQMs ............................................................................................................................... 24

**Step 4: Attestation** ............................................................................................................ 26

**Step 5: Submit** .................................................................................................................. 28
<table>
<thead>
<tr>
<th>Version Number</th>
<th>Date</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>12/29/2011</td>
<td>-</td>
</tr>
<tr>
<td>2.0</td>
<td>10/10/2012</td>
<td>-</td>
</tr>
<tr>
<td>3.0</td>
<td>8/30/2016</td>
<td>Program Year 2015 Updates</td>
</tr>
<tr>
<td>4.0</td>
<td>12/13/2016</td>
<td>Program Year 2016 Updates</td>
</tr>
<tr>
<td>5.0</td>
<td>4/25/2017</td>
<td>Program Year 2017 Updates</td>
</tr>
<tr>
<td>6.0</td>
<td>10/23/2017</td>
<td>Program Year 2017 Updates (from 2018 Inpatient Prospective Payment System Final Rule effective 10/1/17)</td>
</tr>
<tr>
<td>7.0</td>
<td>10/25/2018</td>
<td>Program Year 2018 Updates</td>
</tr>
<tr>
<td>8.0</td>
<td>12/10/2019</td>
<td>Program Year 2019 and Program Year 2020 Updates.</td>
</tr>
</tbody>
</table>
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](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 Cr, Gonzales CA 95016 8810

Confirm information.

Create Login

Enter the necessary information below and click Create Account. * indicates required fields.

User ID: 
Password: 
Confirm Password: 
Select a Challenge Question: 
Your Answer to the Challenge: 
Phone: 
E-mail Address: 

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).

License Information

License Detail

- I have a California professional license.
  - Licensing Board: [Select Licensing Board]

- License Type: [Select License Type]
  - Enter the type of your license number.

- License Number: [Enter License Number]
  - Enter the numbers after the license type on your certificate.

- I practice primarily in an Indian Tribal Clinic or a Federal Clinic and do not have a California License.
  - Other State: [Select State]
  - Other State License Number: [Enter 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 I practice in a Federally Qualified Health Center (FQHC), FQHC Look-Alike, Rural Health Center, or Indian Tribal Clinic that is PA/PAP.

Medi-Cal Managed Care Health and Dental Plans

If you participate in Medi-Cal Managed Care Health and/or Dental Plans, please select all applicable plans:

- Access Dental Plan, Inc.
- Alameda Alliance for Health
- Alamedah (Alameda)
- American HealthGuard Dental
- Anthem Blue Cross Partnership Plan
- CalOptima
- CalParks Health
- Care 1st Health (Hmo Dental)
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.

Establishing Your Eligibility

* Please select one of the following:

- I will be establishing my eligibility to the Medi-Cal EHR Incentive Program on my own using patient encounters at a location(s)/location(s) separate from the practice locations of any group or clinic that has identified me as a member.

- I will be establishing my eligibility to the Medi-Cal EHR Incentive Program on my own but using patient encounters at a location(s) of a group or clinic that has identified me as a member.

Please indicate the groups from which you will be using encounter volumes:

- 9900000045 - Eton Care and Wellness
- 9300000122 - Colusa Care and Wellness
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% 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% 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% 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% or greater Medicaid patient volume level. Do not select this option if you will qualify for the program at the 30% or greater Medicaid patient volume level.

- **Neither**
  Select this option if you do not require the above special conditions to qualify for incentive payments.

- **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:

**Formula Selection**

These formulas affect how your eligibility is calculated.

**Formula 1A**

1A: Total Medicaid Encounters / Total Patient Encounters

**Formula 2A**

2A: (Total Medicaid Patients Assigned to a Panel / Total Medicaid Encounters) / (Total Patients Assigned to a Panel / Total Patient Encounters)

Note: Patients assigned to a panel (whether Medicaid or other payer) should only include active panel patients who were seen at least once in the 12 months preceding the 90-day representative period.

Enter your patient volumes and click “Save”:

**Patient Volumes**

Please enter your patient volumes below. Volumes from California are required. If you practice in other states choose the appropriate state and complete your volume information. You must enter data in every field. Enter a zero if you do not have data to report for any field.

<table>
<thead>
<tr>
<th>State</th>
<th>Total Patient Encounters</th>
<th>Total Medicaid Encounters</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>CA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Select</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Patient Volume Percentage**

Formula Used: 1A

Eligible Providers must have a Medicaid volume >= 29.5% to be eligible for the Medi-Cal EHR Incentive Program. Pediatric Providers must have a Medicaid volume >= 19.5% to be eligible for the Medi-Cal EHR Incentive Program.

☑ Meets eligibility criteria.

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.

<table>
<thead>
<tr>
<th>MU Section</th>
<th>Stage 3 Provider Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>MU Reporting Period</td>
<td>Choose a minimum 90-day meaningful use reporting period from within the current calendar year.</td>
</tr>
<tr>
<td>CQM Reporting Period</td>
<td>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.</td>
</tr>
<tr>
<td>EHR Certification</td>
<td>Enter the CMS EHR Certification ID for the EHR technology used to fulfill MU.</td>
</tr>
<tr>
<td>Objectives</td>
<td>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.</td>
</tr>
<tr>
<td>Public Health Reporting</td>
<td>Pass at least two out of five measures or attest to all five measures without failing any measure. Exclusions do not count as failing.</td>
</tr>
<tr>
<td>Clinical Quality Measures (CQMs)</td>
<td>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.</td>
</tr>
<tr>
<td>Documentation Requirements</td>
<td>Upload <a href="#">MU documentation</a>.</td>
</tr>
</tbody>
</table>


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:

<table>
<thead>
<tr>
<th>Key</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔️</td>
<td>Passed MU Requirement</td>
</tr>
<tr>
<td>❌</td>
<td>Failed MU Requirement</td>
</tr>
<tr>
<td>🚨</td>
<td>Notice (open item for specific notice details)</td>
</tr>
<tr>
<td>🟢</td>
<td>In Progress</td>
</tr>
</tbody>
</table>

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.

Once all objectives are passed (as denoted by the green checkmarks), providers will be allowed to proceed to Step 4: Attestation.

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

Reporting Periods

MU Reporting Period

Start Date  
End Date

Enter the start date for a 90-day reporting period that must start and end between
The end date will be automatically calculated but can be changed so that the reporting
more than 365 days.

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.

CQM Reporting Period

Start Date  
End Date

Enter the start date of a 90-day CQM reporting period. The end date will be automatically calculated as 90 days from the
start date. The CQM reporting period must begin and end in the same calendar year as the Program Year for which you are
applying.
Location Information

The locations used to establish eligibility will be displayed here.

You must add all locations where you practice and designate the percentage of patient’s records in certified EHR technology at each location.
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.
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.

The total number of selected CQMs will be displayed here.
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.

---

**CMS 75**

**Title:** Children who have dental decay or cavities

**Description:** Percentage of children, ages 0-20 years, who have had tooth decay or cavities during the measurement period.

Responses are required for the clinical quality measures displayed on this page.

**Numerators:**

- Children who had cavities or decayed teeth.

**Denominators:**

- Children, age 0-20 years, with a visit during the measurement period.

* Numerator: __________  * Denominator: __________

---

**Step 4: Attestation**

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

4. Review, Sign, and Attach 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.
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**

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Please note: The “optional attestation items” are in fact optional. Initials are not required.
The final step in the application process is submitting the attestation:

5. Submit

Submit Application.

You have completed all required information in your application for the Medi-Cal EHR Incentive Program. If you would like to submit it to the state, click the submit button below. If you have any questions, contact the help desk at (866) 873-0100 or by email at SLRhelpdesk@care.coop.

- Submit Application
- Cancel and do not send 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.