State Level Registry (SLR) Quick Start Guide for Providers

Program Year 2018

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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	6/12/2019	Updated to include information from the State Level Registry Quick Start Guide for Proxies.

Introduction

The State Level Registry (SLR) portal is available for eligible providers to apply to the Medi-Cal EHR Incentive Program. Providers can apply for Program Year 2018 beginning June 21, 2018. Providers will be able to attest to either Stage 2 or Stage 3. Attestation to Stage 3 is optional. All providers that have attested to Meaningful Use (MU) previously will have a one-year clinical quality measure (CQM) reporting period and will need to wait until January 1, 2019 to submit their attestations.

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 should review the following guide before creating an account in the SLR.

- 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 using a proxy representative will receive notification that information was entered on their behalf when logging in to the SLR. The provider is given the choice of accepting the information or deleting it and entering their own information.

- Proxy representatives can enter information for multiple providers (one at a time) but only one proxy representative can enter information on behalf of one provider.

- 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% Medicaid volume threshold, Meaningful Use (MU) requirements must still be met in order to qualify.

- The proxy representative 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.

Registering for the Medi-Cal EHR Incentive Program

Registration for providers is a two-step process.

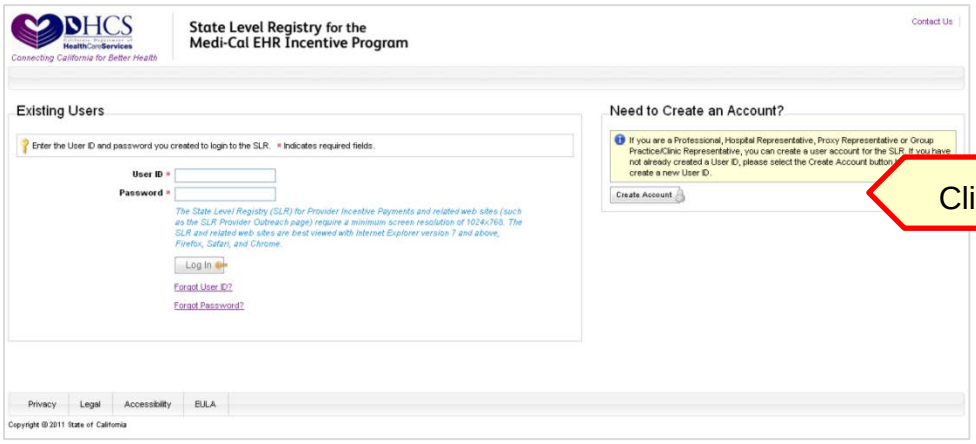
1. Providers must have already registered with the Centers for Medicare and Medicaid Services (CMS).

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

This quick-start guide will walk you through the State Level Registry registration process.

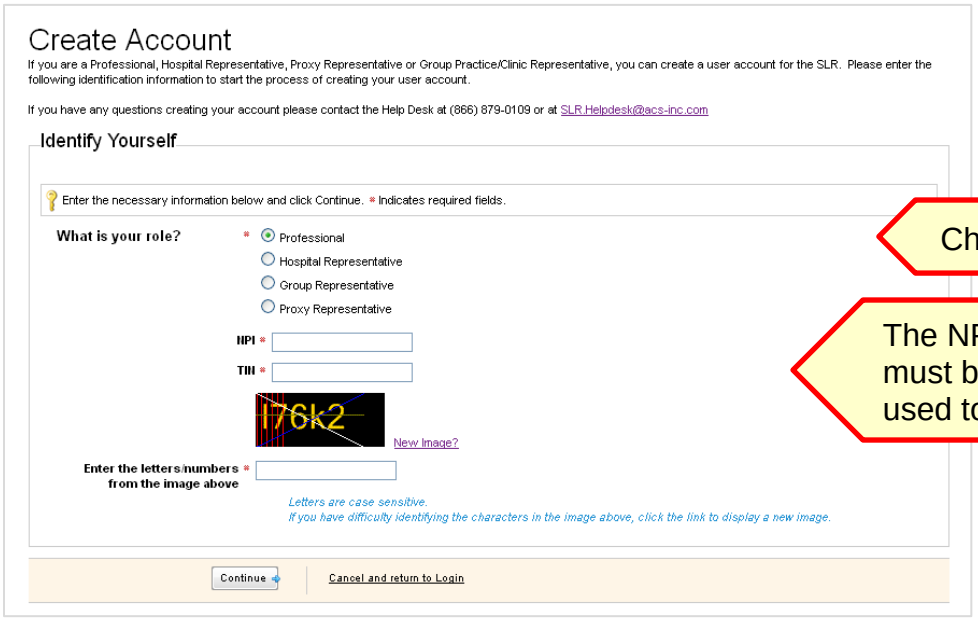
Create an Account

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



Click “Create Account.”

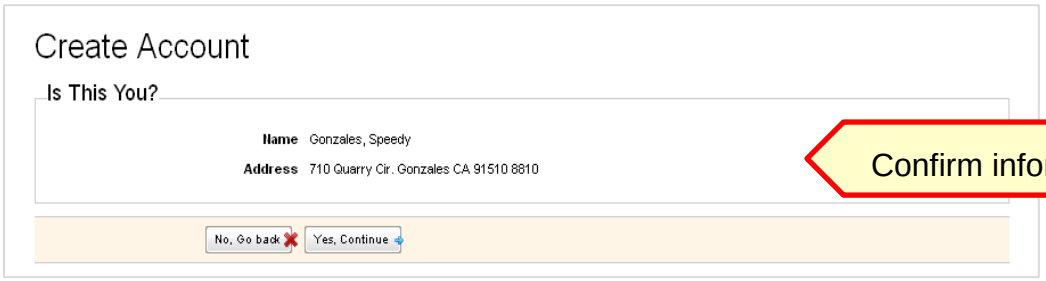
Choose the “Professional” role and enter your NPI and TIN.
It is important to note that the NPI and TIN entered here must be the same NPI/TIN combination used to register with CMS.

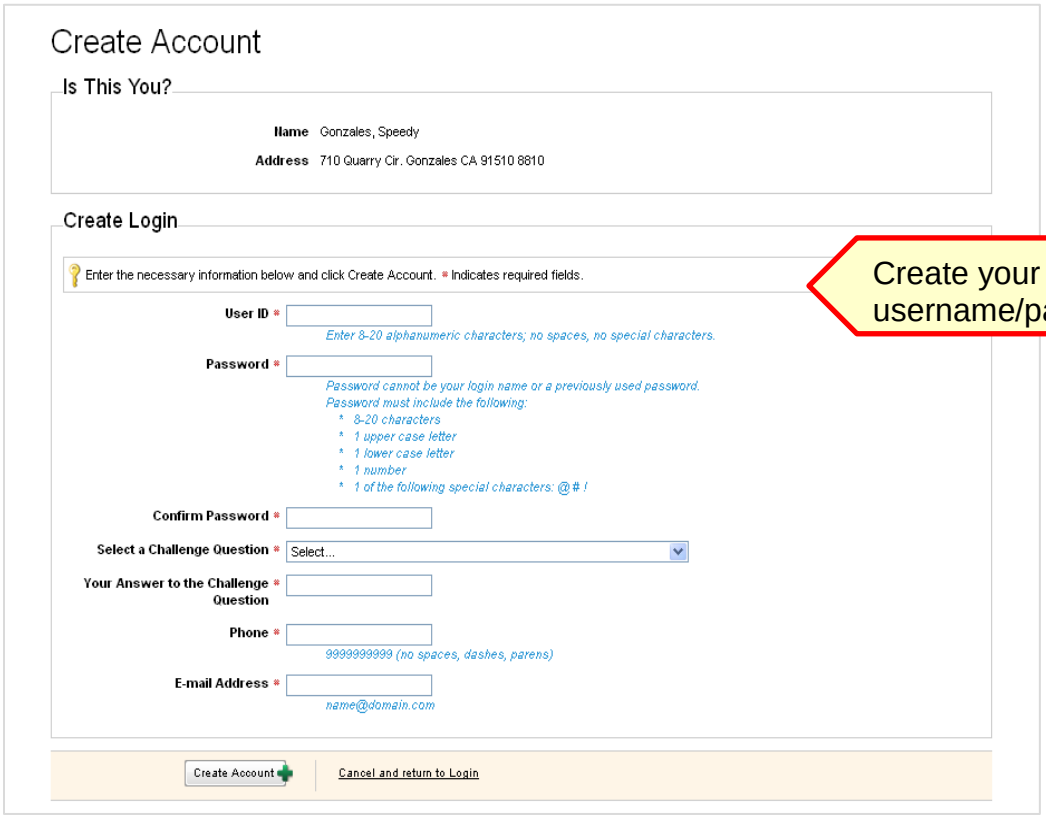


Choose “professional.”

The NPI/TIN entered here must be the same NPI/TIN used to register with CMS.

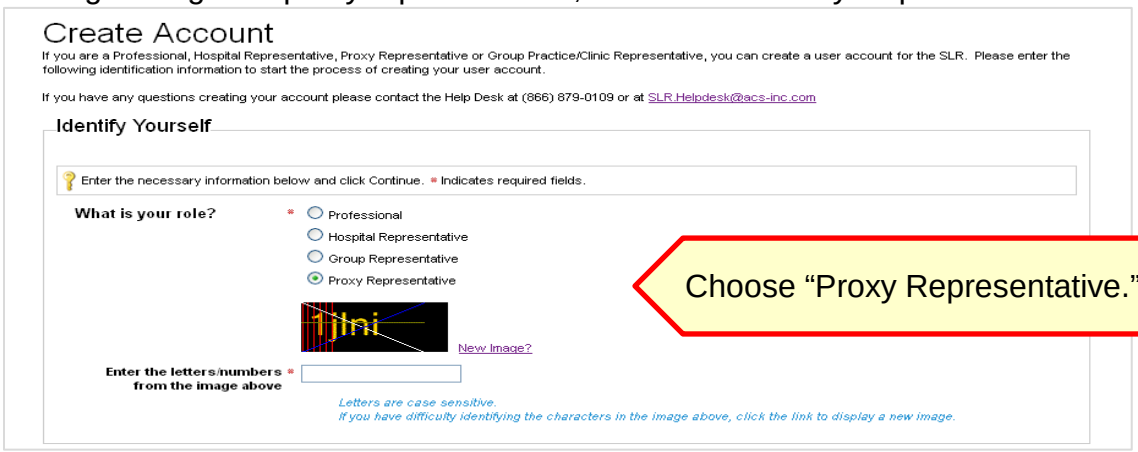
Upon clicking “Continue,” you will be prompted to verify your name and address before you can complete your registration:



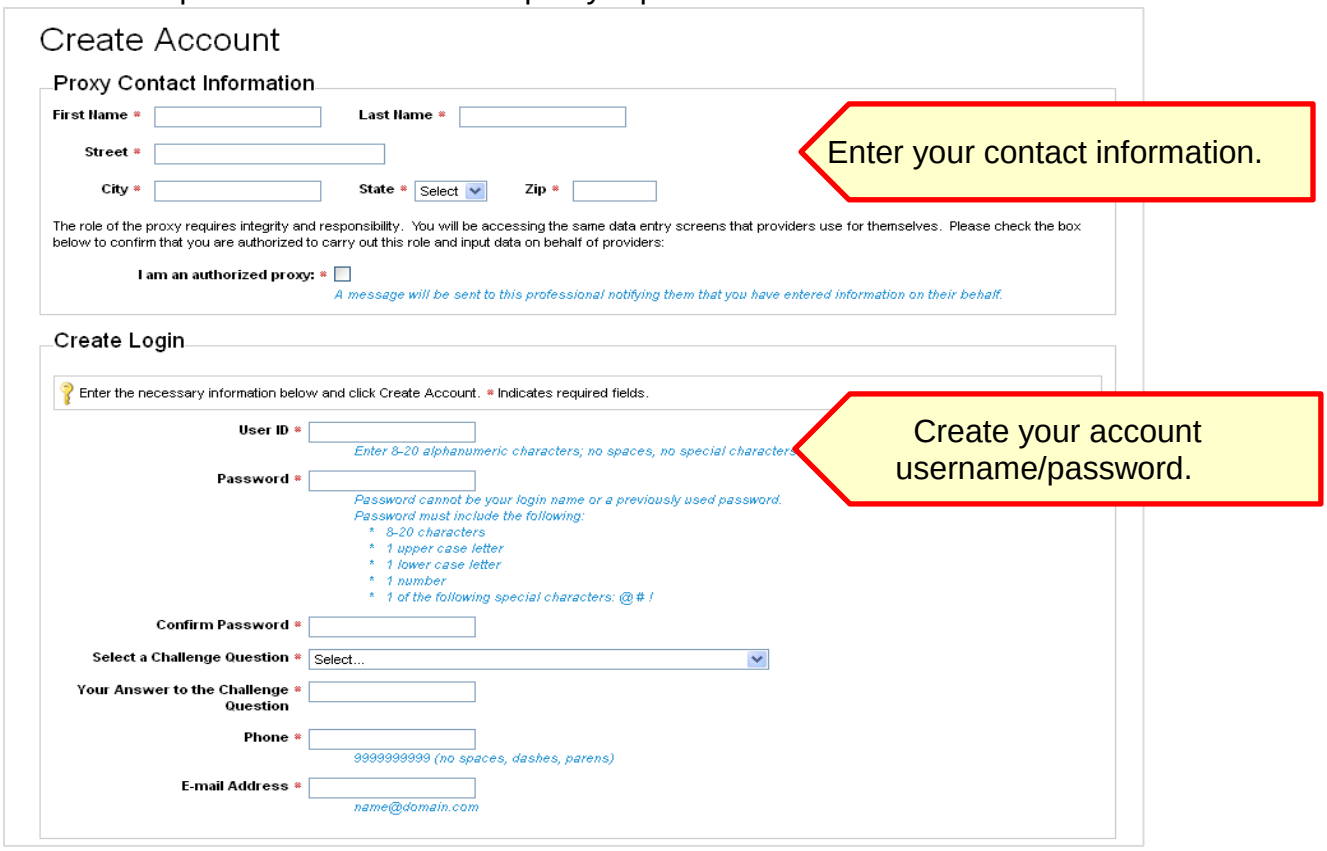


Create a Proxy Account

If you are registering as a proxy representative, choose the “Proxy Representative” role:



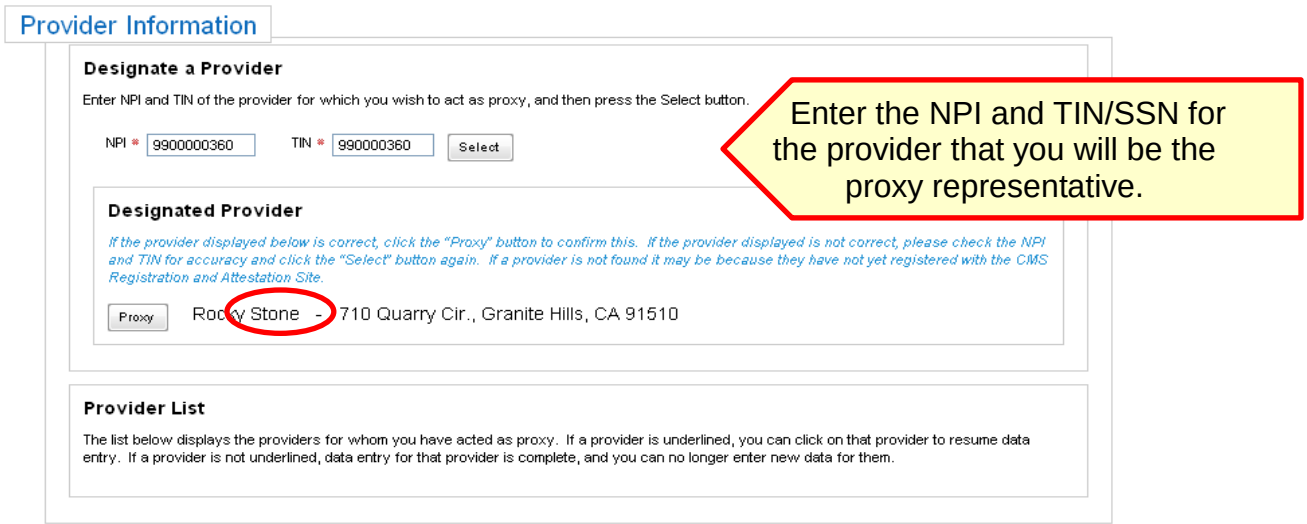
Enter the required data to create the proxy representative account:



Proxy Home: Searching for Providers

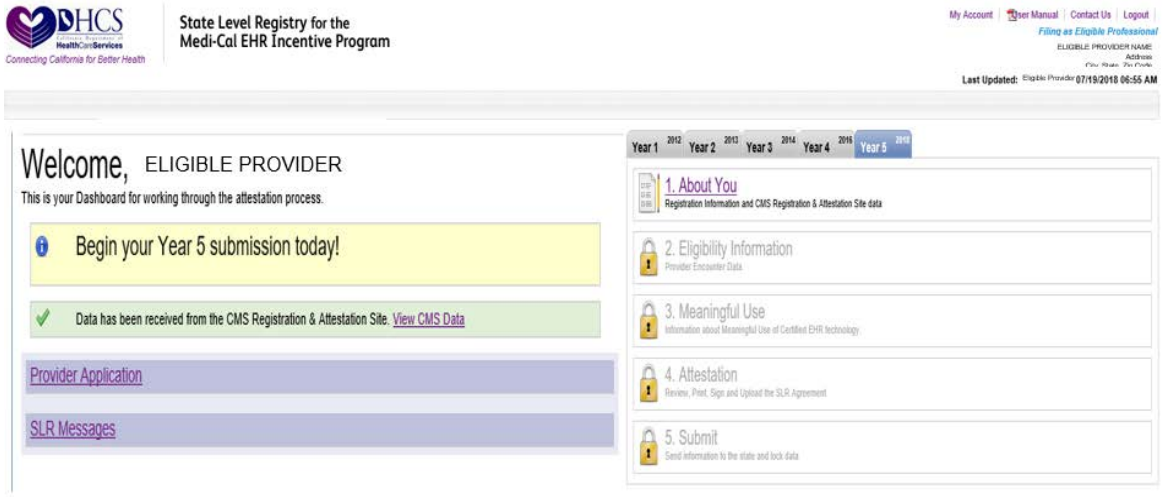
The proxy representative may enter data for one provider at a time. To search for a provider, enter the provider's NPI and TIN/SSN. This should be the same NPI/TIN that the provider used when registering with the CMS Registration and Attestation site. Click "select" after the data has been entered.

Confirm that the provider displayed is correct, then click the "Proxy" button to begin entering data. If the provider is not found, it may be because they have not registered with the CMS Registration and Attestation site.

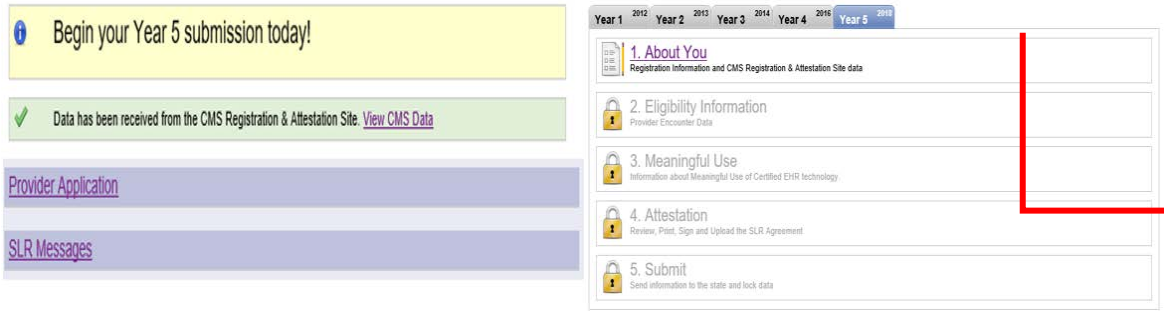


Dashboard

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.



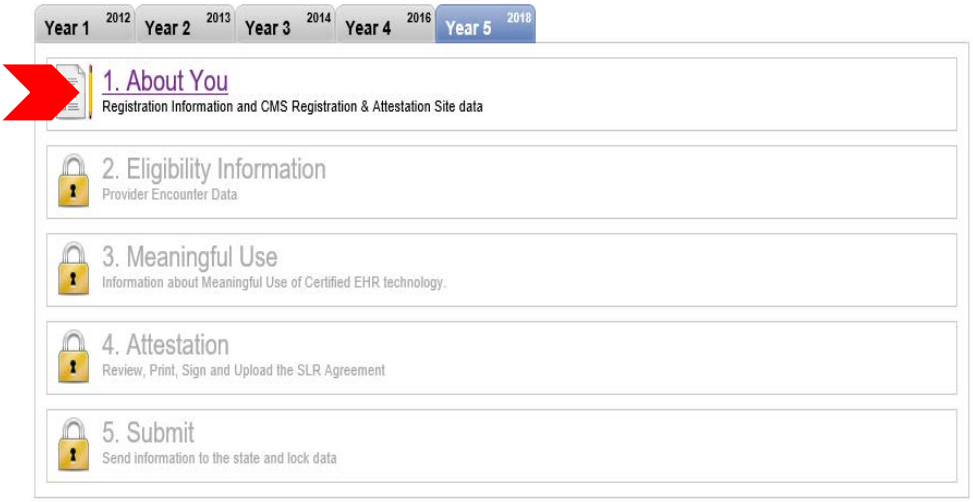
Please note that providers cannot apply for the current year until their application for the previous year has been reviewed (and subsequently approved or denied) by the state. The provider below has been approved by the state for Year 1/2012, 2/2013, 3/2014, 4/2016, and is able to apply for Year 5/2018.



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

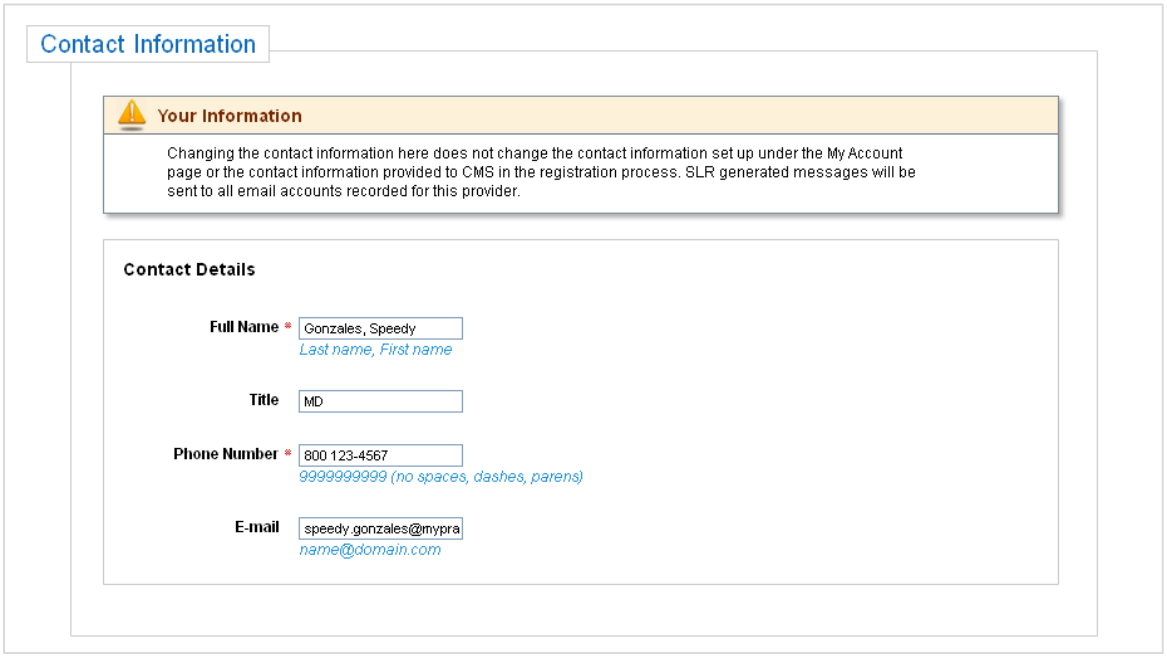
Step 1 in the SLR requires providers to enter contact information, license information, and group/clinic participation (if applicable).



Contact Information

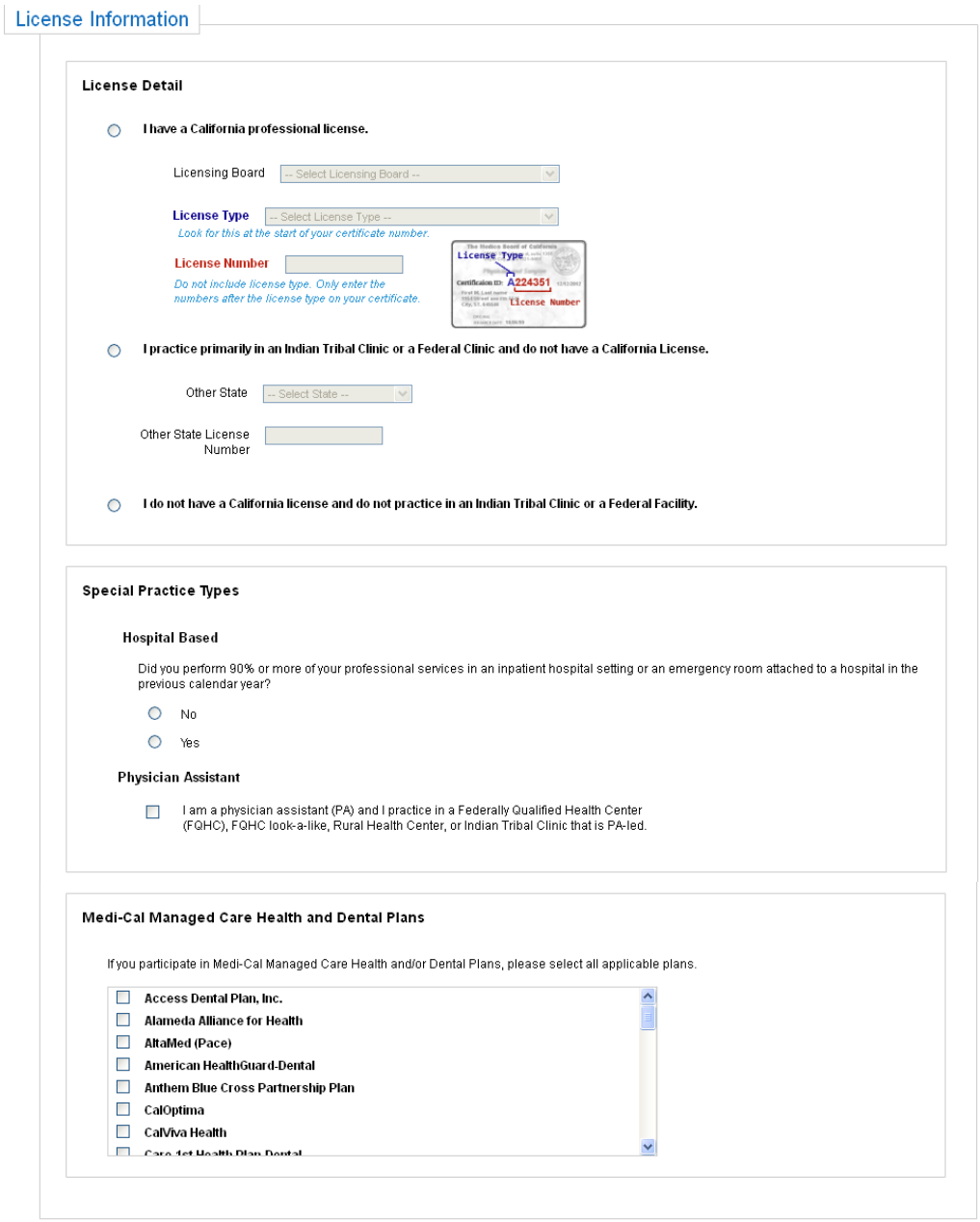
Enter the name and contact information for the contact person on the account.

For providers who have previously registered with Medi-Cal, this section will be pre-populated with the information entered from the previous year.



License Information

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

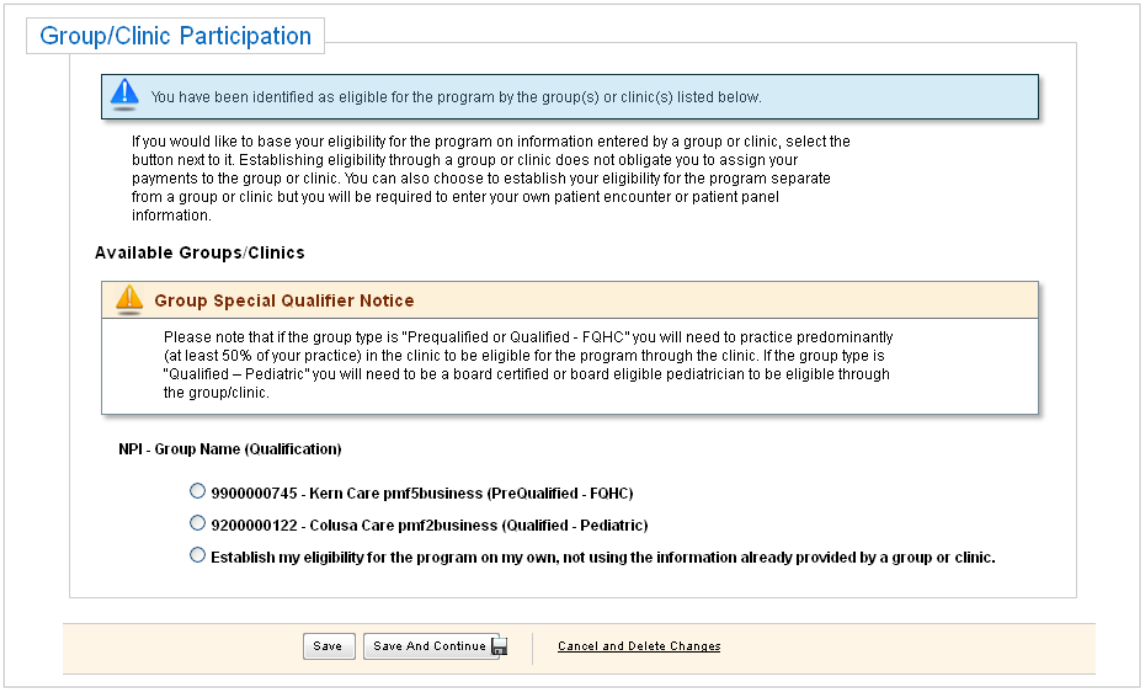


Group/Clinic Participation

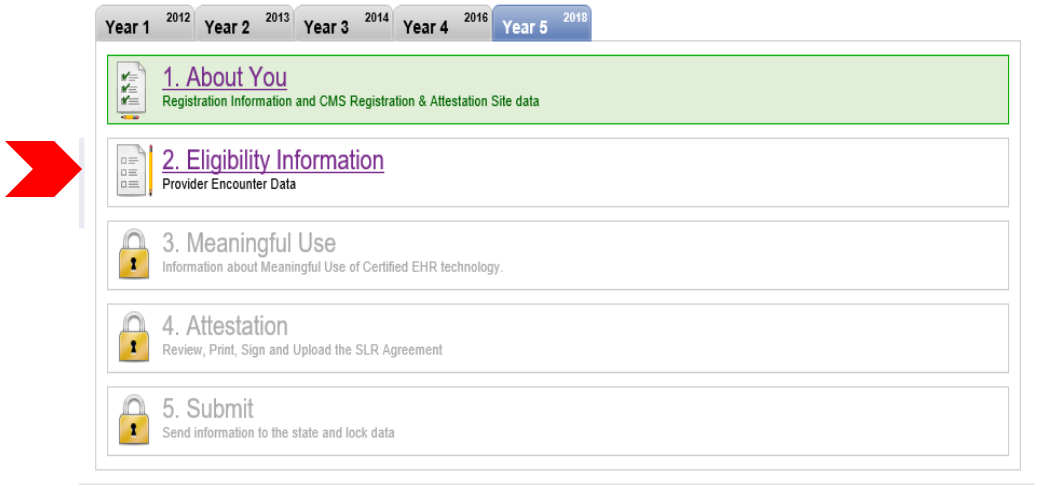
The final part of Step 1 is selecting how you would like to participate in the program – with a group (if applicable) or on your own as an individual provider.

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.

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



Step 2: Eligibility Information



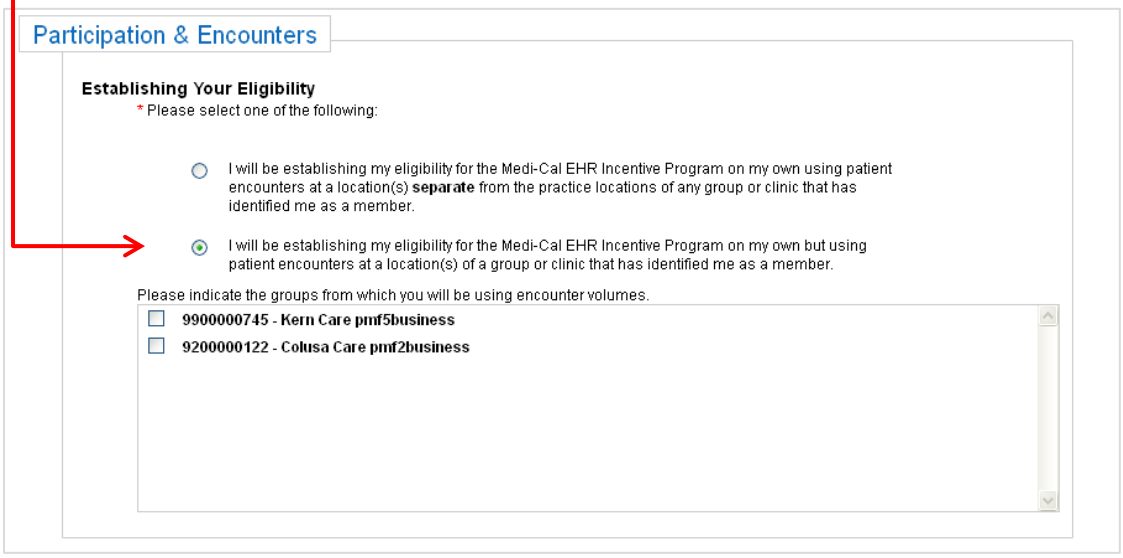
Participation & Encounters

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.

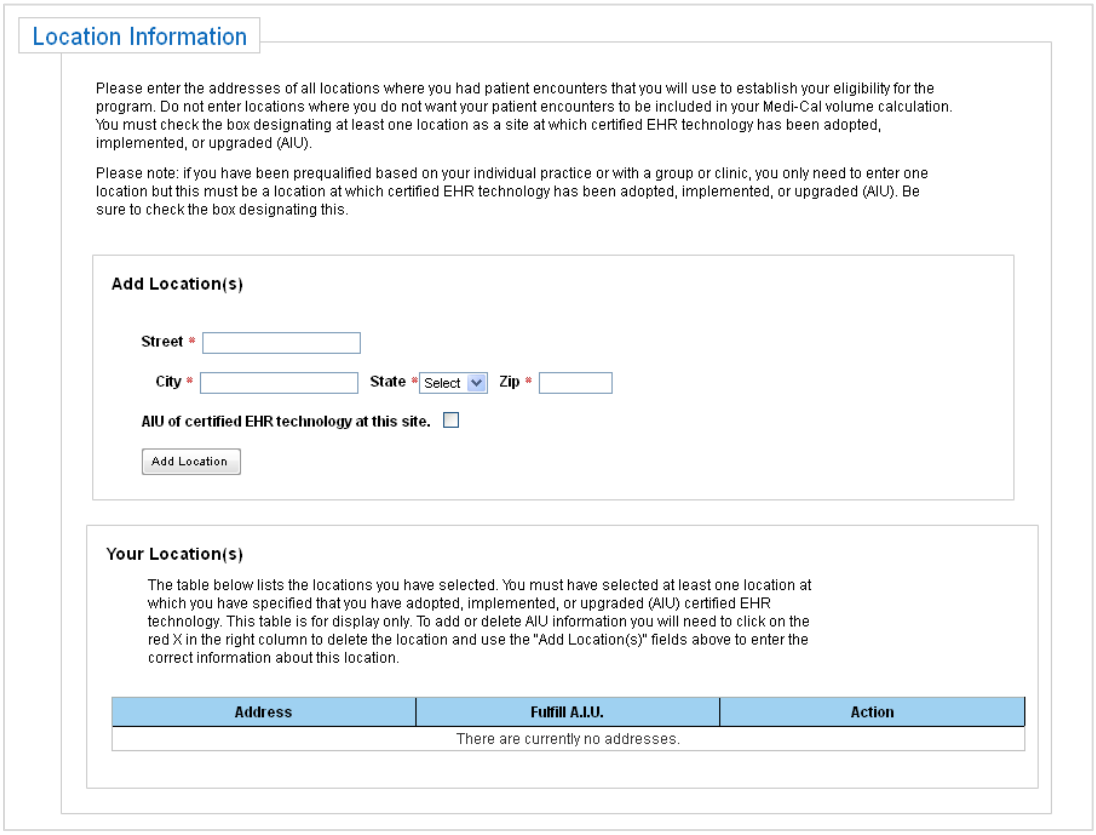
Note: If a provider chooses this option, they will be required to specify the group/clinic from which they are using encounter volumes. This action will "close" the group and restrict other providers from using the group's volumes. Providers that choose this option will be instructed to contact the help desk at 866-879-0109 before they can proceed with submitting their attestation.



Location Information

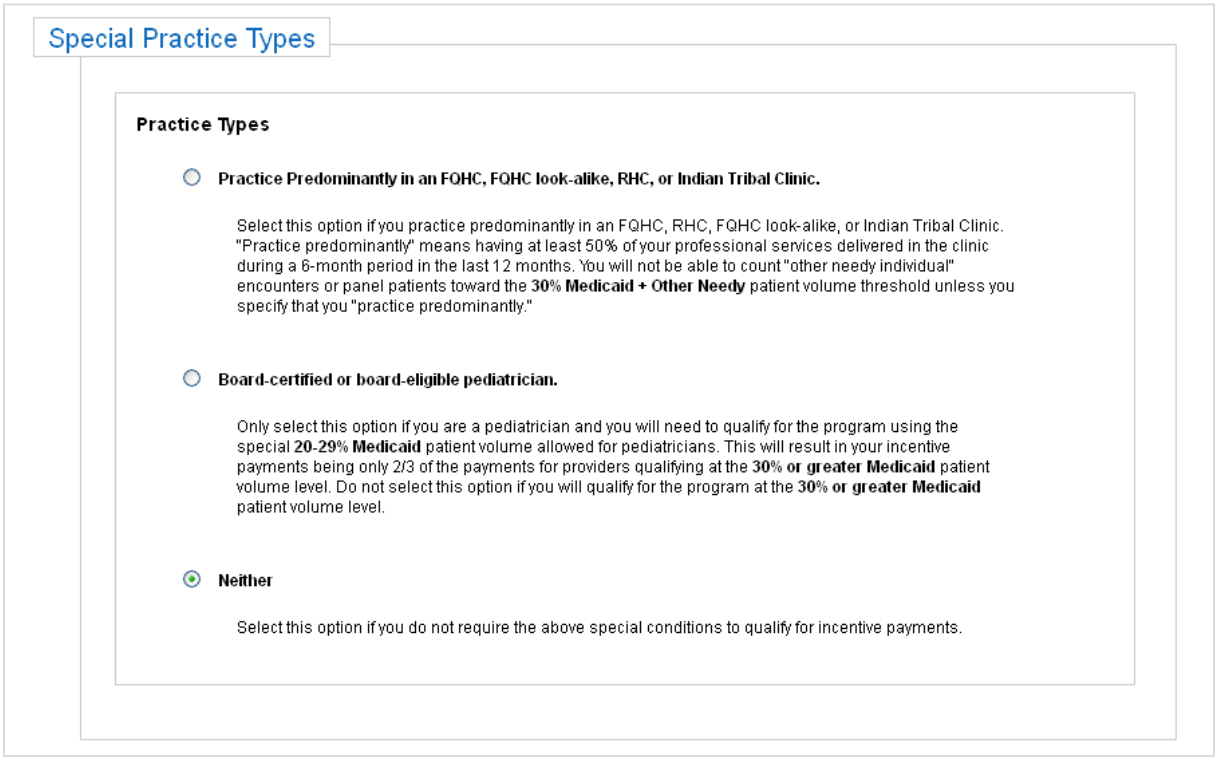
Enter the addresses of all locations where you had patient encounters that you will use to establish your eligibility for the program. Do not enter locations where you do not want your patient encounters to be included in your Medi-Cal volume calculation.

You must check the box designating at least one location as a site at which certified EHR technology has been adopted, implemented, or upgraded.



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.

Provider's Patient Volumes

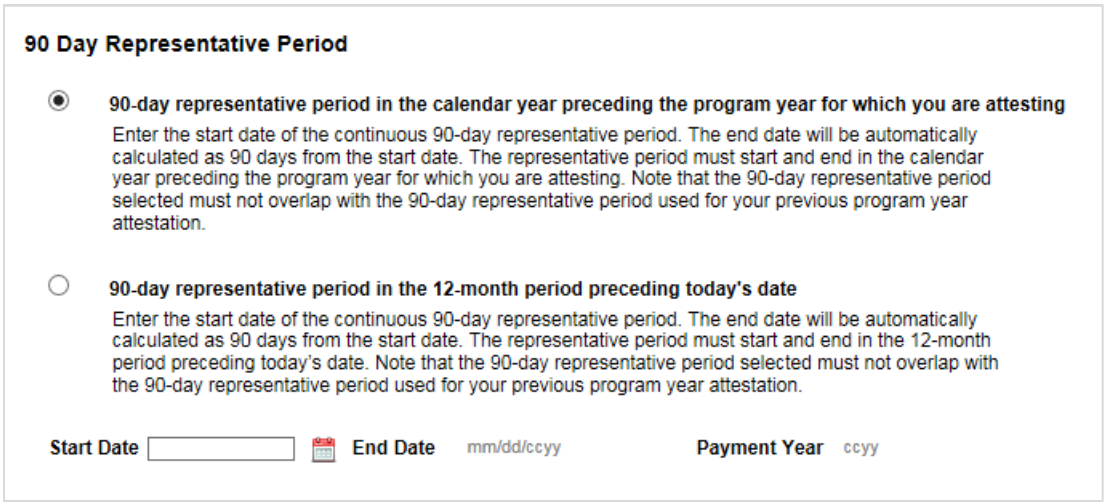
Note: For providers who choose to establish eligibility as part of a group in Step 1, this data will be pre-populated with group/clinic volumes (entered by the group/clinic representative).

In each participation year (years 1 through 6) providers must show that they meet the minimum 29.5% Medicaid Encounter volume requirement (19.5% for pediatricians) within any 90-day period from the previous calendar year, **or** in the 12-months prior to attestation. The Provider Eligibility Workbook is a useful resource that can assist in calculating your volumes and determining eligibility.

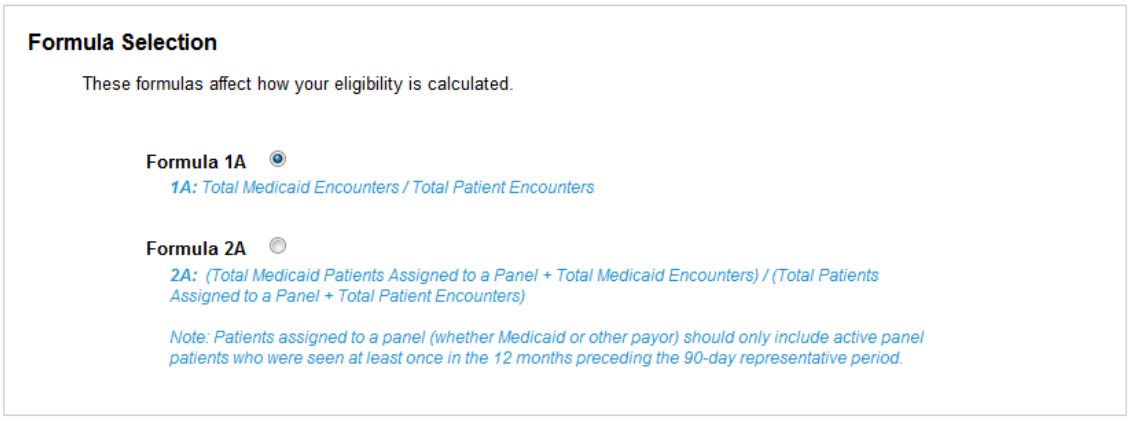
Providers must first choose the 90-day representative period from which patient volumes will be derived. There are two approaches available:

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.

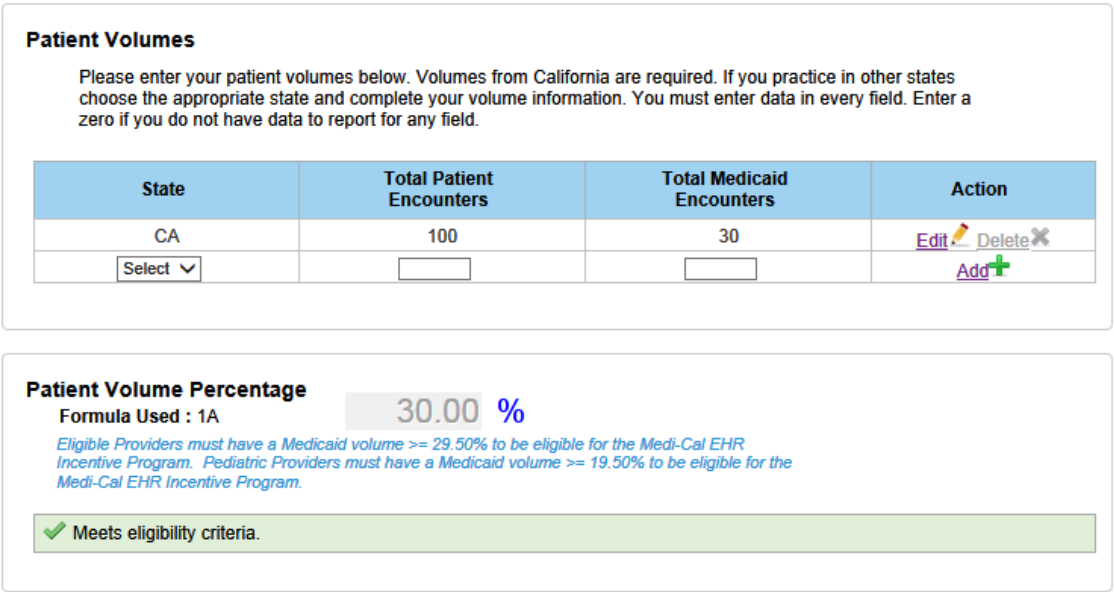
90-day Representative Period in the *12 months prior to attestation*:
The representative period must start and end in the 12-month period preceding the date that the provider submits their attestation. Note that the 90-day representative period selected must not overlap with the 90-day representative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

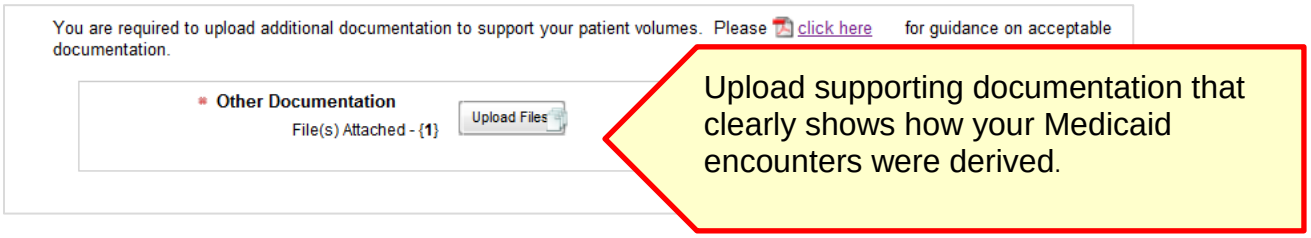


To qualify, providers must have a minimum of 29.5% Medicaid volumes (pediatricians can qualify for a reduced incentive payment with 19.5%-29% Medicaid volumes). Providers who practice predominantly in an FQHC, RHC, FQHC Look-Alikes, or Indian Tribal Clinics can qualify with Medicaid + Other Needy Individual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

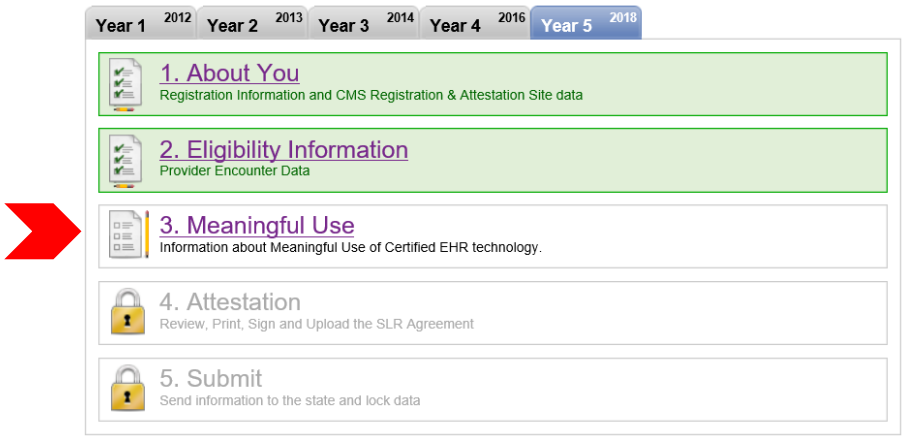
Patient Volumes – Supporting Documentation

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.

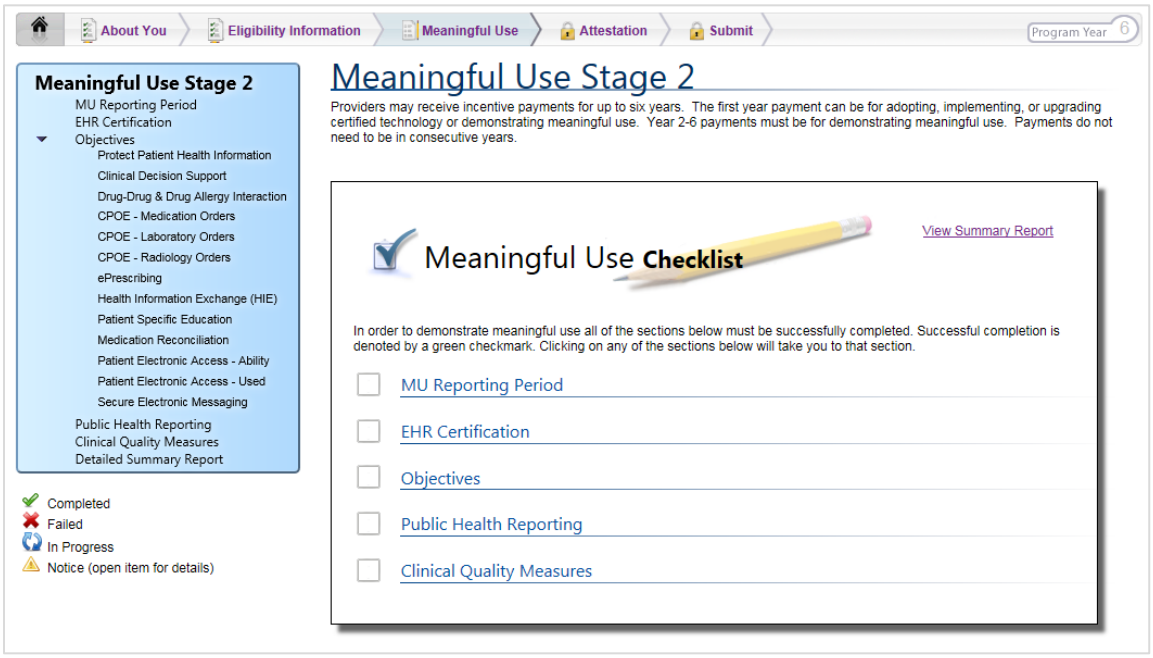
MU Stage 2 and Stage 3

In Program Year 2018, providers have the option to attest to Stage 2 or Stage 3.

The information in this section pertains to Stage 2 MU. Information specific to Stage 3 MU will be provided in the Stage 3 MU Requirements section beginning on page 23.

Stage 2 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.

At any point in 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.

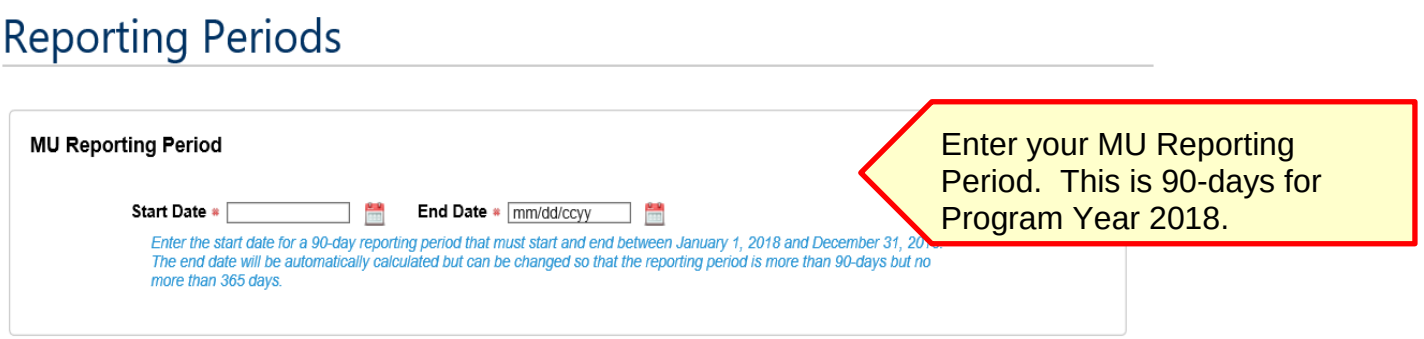
Reporting Periods

In Program Year 2018, all providers are able to use a 90-day MU reporting period regardless of which year of MU they are in.

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.

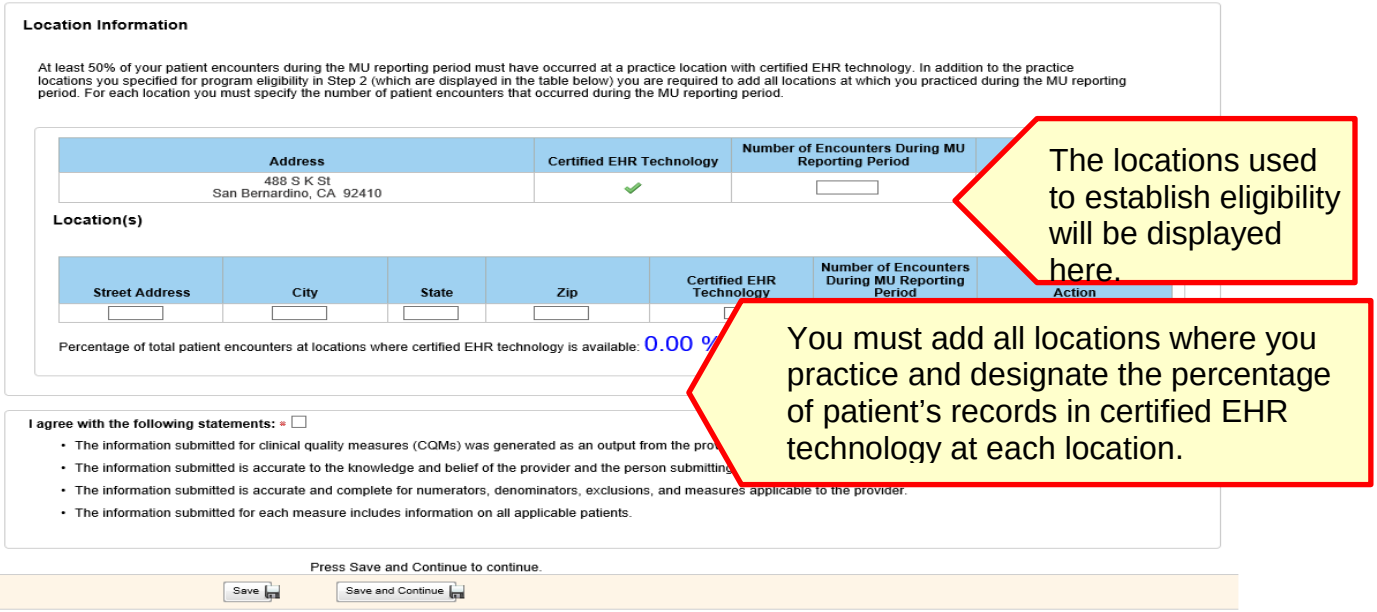
MU Reporting Period



CQM Reporting Period

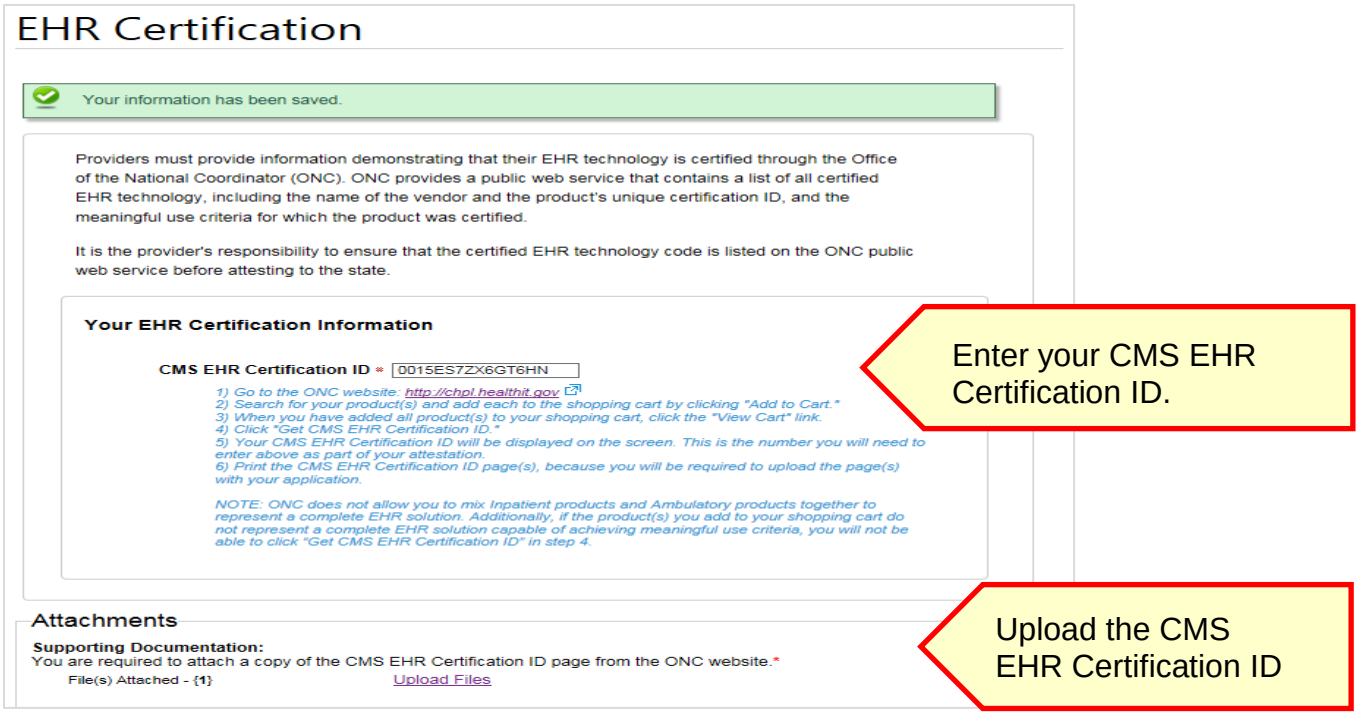
Providers reporting MU for the first time are required to choose at least a 90-day CQM Reporting Period. This period can be edited to be longer than 90-days by manually entering the end date in the corresponding field. The reporting period must fall within the current calendar year. Providers who have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

Location Information



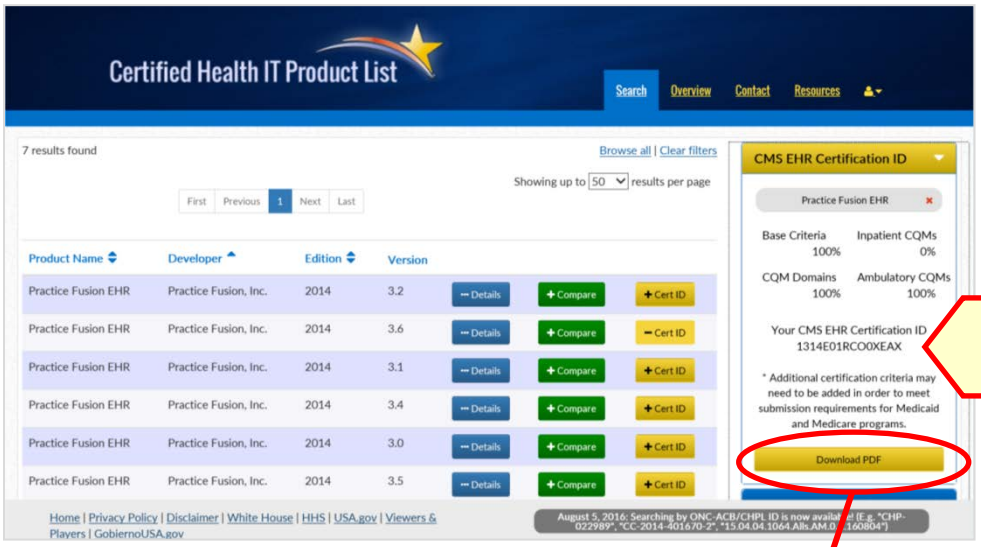
EHR Certification

Enter the CMS EHR Certification ID for the certified technology used to demonstrate MU. In Program Year 2018, 2014, 2014/2015 COMBO, or 2015 CEHRT are acceptable to meet Stage 2 MU. Only 2014/2015 COMBO or 2015 CEHRT are acceptable to meet Stage 3 MU.

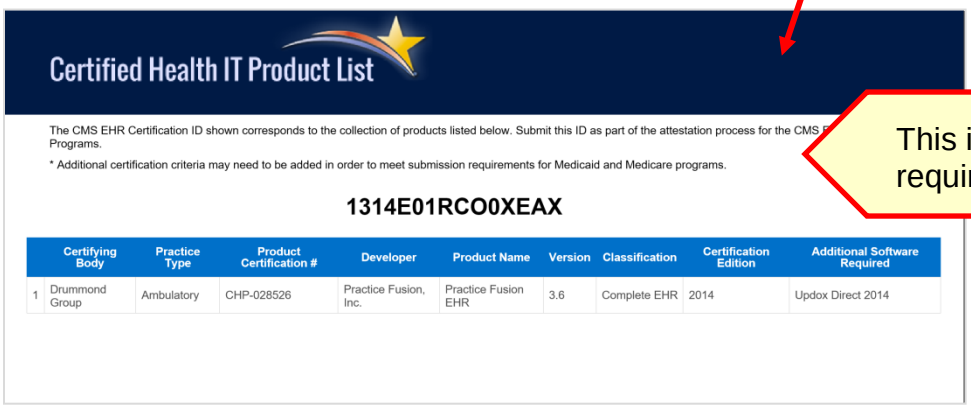


How to find your CMS EHR Certification ID:

1) Go to the ONC website: https://chpl.healthit.gov
2) Search for your product(s) and click "+ Cert ID" for each of your product(s).
3) When you've added all product(s), click the "Get EHR Certification ID" button to retrieve your ID.
4) Your CMS EHR Certification ID will be displayed on the screen. This is the number you will need 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.



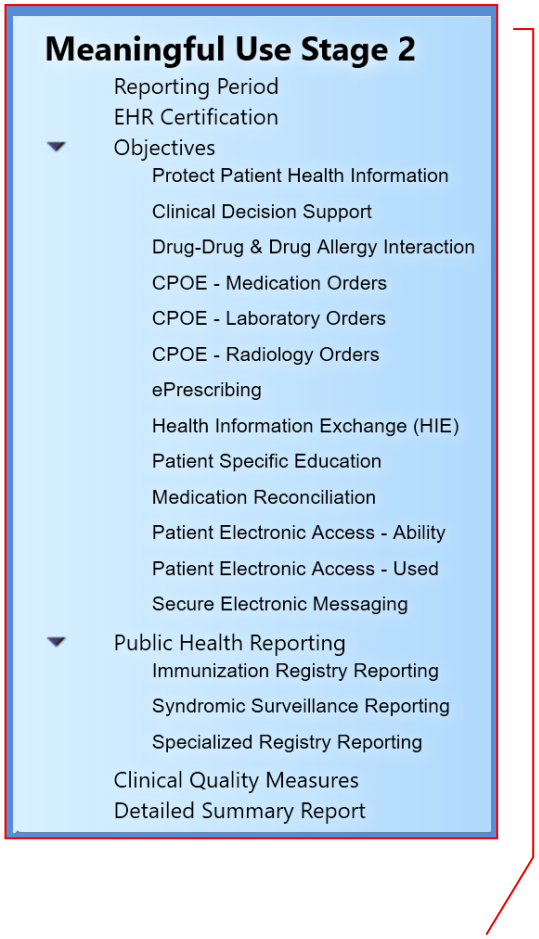
This is your CMS EHR Cert ID.



This is the page you are required to upload.

Stage 2 MU Requirements

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

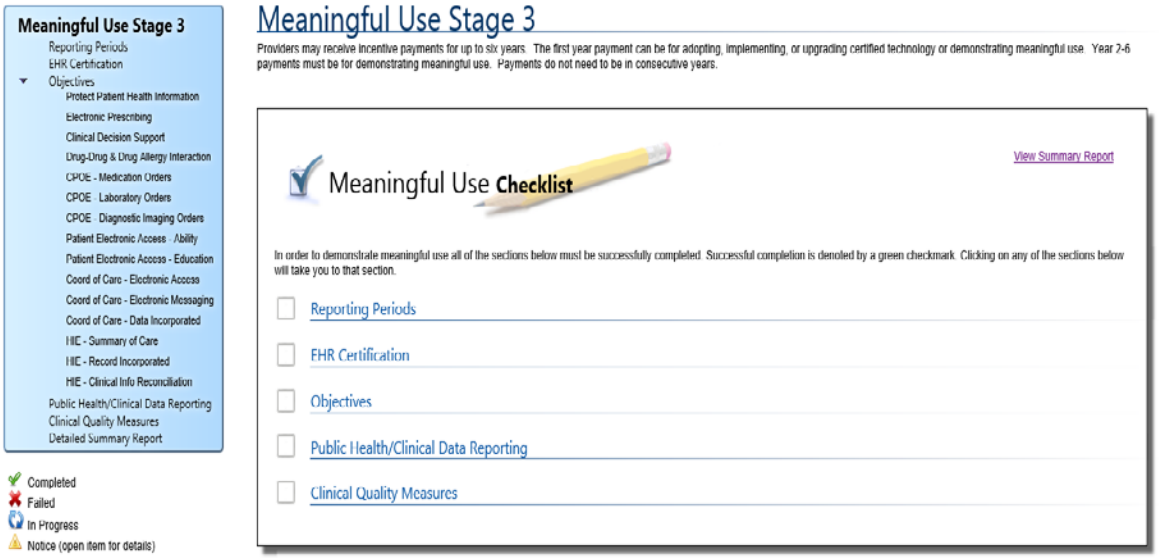


MU Section	Stage 2 Provider Requirements
MU Reporting Period	Choose a 90-day meaningful use reporting period from within the current calendar year.
CQM Reporting Period	1st Year MU – Choose a 90-day CQM reporting period from within the current calendar year. Subsequent Year MU – Report on a full calendar year.
EHR Certification	Enter the CMS EHR Certification ID for the EHR technology that you are using to fulfill MU.
Objectives	Pass all 10 Objectives (13 Measures).
Public Health Reporting	Pass 2 Measures or report on all 4 Measures without failing any measure. Exclusions do not count as failing.
Clinical Quality Measures (CQM)	Providers must complete 6 CQMs that are relevant to their scope of practice. Zeros may be entered in numerators and denominators.

Stage 3 MU Progress

All of the steps for Stage 3 with regard to reporting periods, locations, EHR certification are the same as displayed for Stage 2 above, and will not be repeated here.

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:

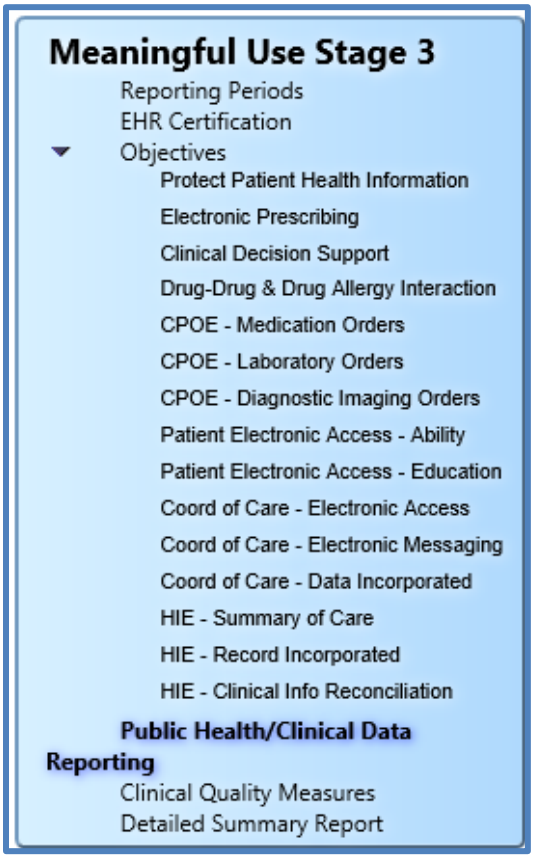
Key	
	Passed MU Requirement
	Failed MU Requirement
	Notice (open item for specific notice details)
	In Progress

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.

At any point in 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.

Stage 3 MU Requirements

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

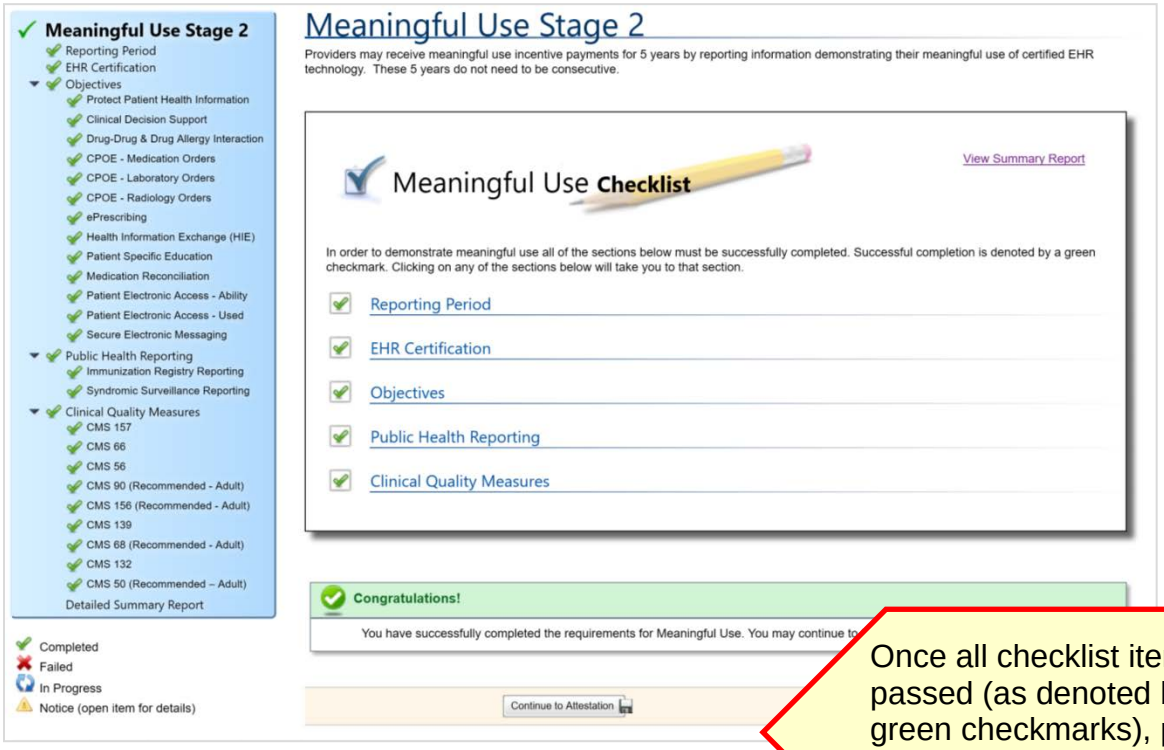


MU Section	Stage 3 Provider Requirements
MU Reporting Period	Choose a 90-day meaningful use reporting period from within the current calendar year.
CQM Reporting Period	1st Year MU – Choose a 90-day CQM reporting period from within the current calendar year. Subsequent Year MU – the CQM Reporting Period is 90-days for all participants.
EHR Certification	Enter the CMS EHR Certification ID for the EHR technology that you are using to fulfill MU.
Objectives	Pass all 8 Objectives (13 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. The Electronic Case Reporting measure is optional for 2018. Any EP choosing not to report this measure can and should claim an exclusion.
Clinical Quality Measures (CQM)	Providers must complete 6 CQMs that are relevant to their scope of practice. Zeros may be entered in numerators and denominators.

MU Checklist and Summary

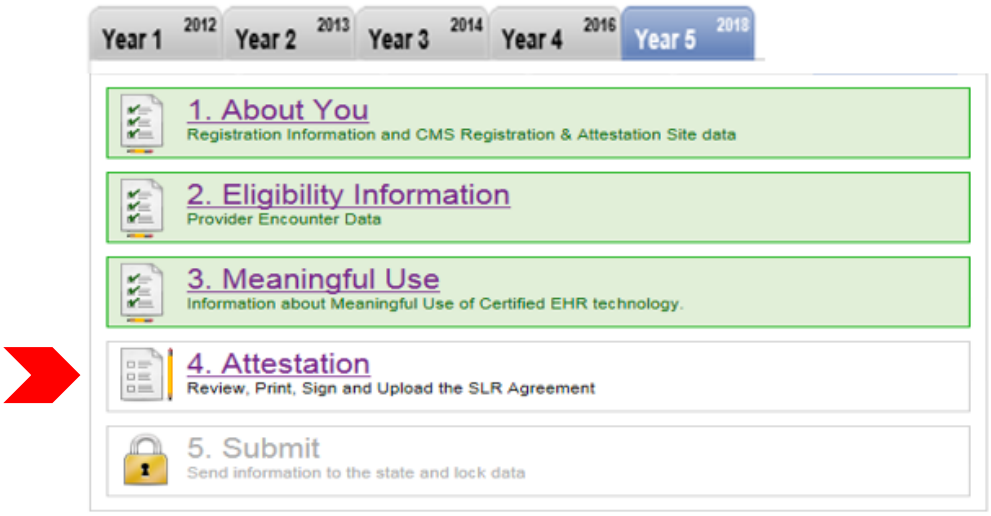
At any point during the process, you can click on the "Detailed Summary Report" link at the bottom of the navigation menu to access a PDF report that shows your entries for each section. The MU checklist and summary is the same format for Stage 2 and Stage 3.

Once all MU data is complete and all items 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.

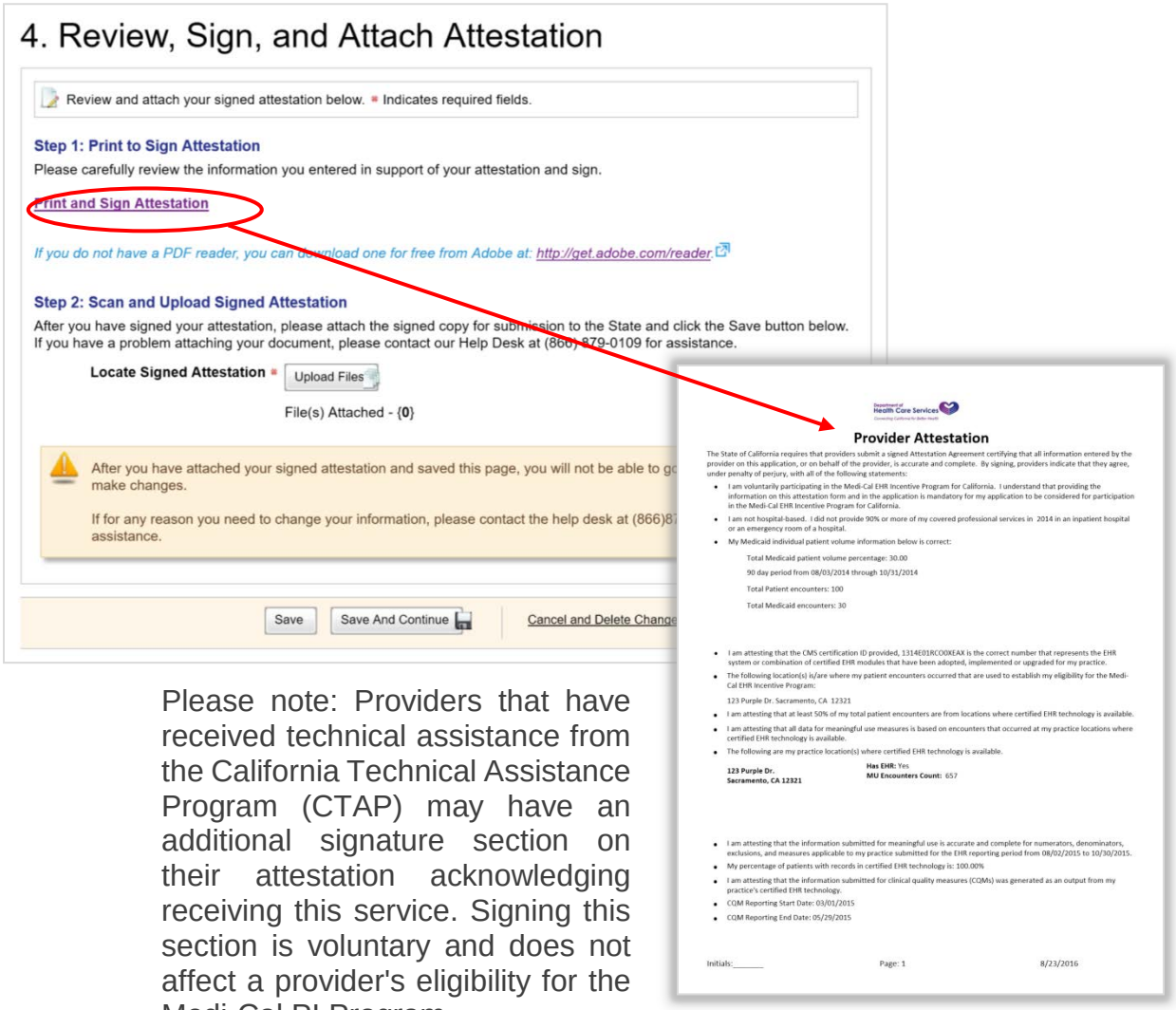


Once all checklist items are passed (as denoted by the green checkmarks), providers will be allowed to proceed to Step 4: Attestation.

Step 4: Attestation

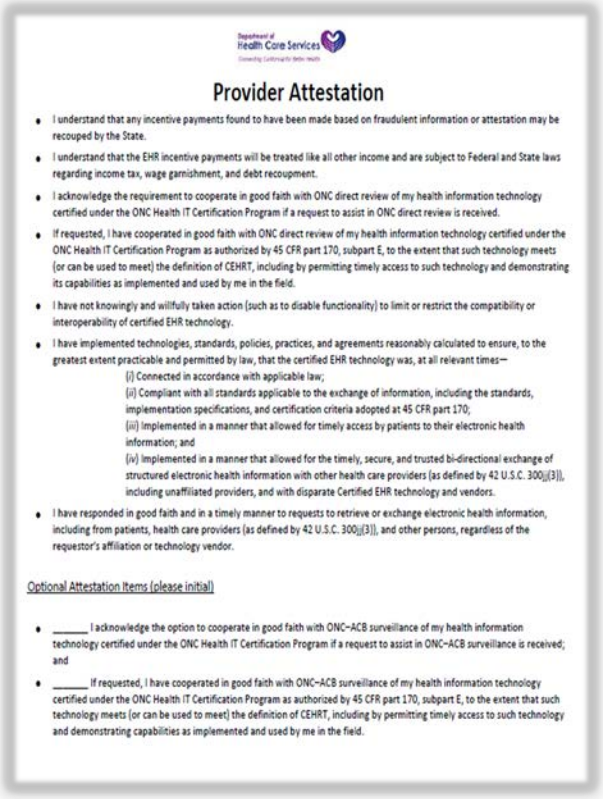


Providers will be required to print, physically sign, and upload their Provider Attestation.



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 PI 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. 300j(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. 300j(3)), and other persons, regardless of the requestor's affiliation or technology vendor.

Optional Attestation Items (please initial)

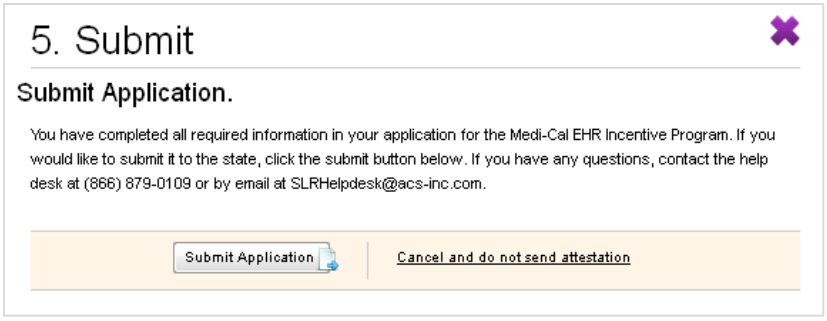
- _____ I acknowledge the option to cooperate in good faith with ONC-ACB surveillance of my health information technology certified under the ONC Health IT Certification Program if a request to assist in ONC-ACB surveillance is received; and
- _____ If requested, I have cooperated in good faith with 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 items listed as optional attestation items are optional. Initials are not required.

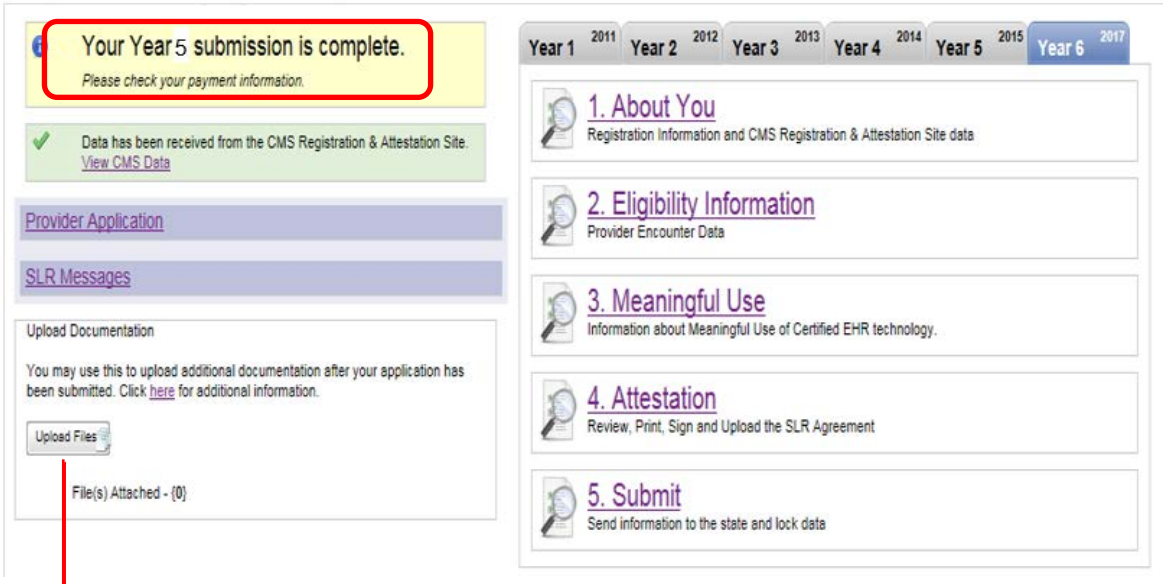
Once the provider uploads and saves the attestation, the previous steps become un-editable and the account will be in view-only mode.

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.